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A Glowing Torch

LATE AUGUST and early September are epoch-making periods in our schools of nursing as hundreds of young women throng to the doors opening a new way of life for them. Their gradual growth and maturity in their chosen profession is an interesting spectacle. The three years that elapse while this transformation is taking place seem so long at the beginning, so short in retrospect.

The same months that herald the arrival of new classes are also a time of farewells to departing new graduates. Trunks appear to be crammed with accumulated treasures. A pleasantly piquant air of sadness mixed with excitement pervades the nurses' home as plans for the future are discussed. "How long a holiday are you going to have before you take a job?" "Where are you going to work?" "When are you getting married?" "Be sure to send me your address so we can keep in touch!" On and on and on flows the chatter. Squeals of laughter — then silence. They have gone.

Where do they go— these hundreds of shining new additions to the currency of nursing service? Many return to the staff of their own hospital — at least until the registered nurses' examinations. Others hasten, dewy-eyed, to the joys and responsibilities of building a new home — better wives because they are good nurses. A very few enrol immediately for post-graduate courses — too soon, actually, to have acquired the feeling of being a graduate nurse. Some waver between working here, there, or elsewhere.

There is a lively challenge to each one of these new graduates in the rapidly developing northland of Canada. If many of them would give even a few years of service in some of the out-of-the-way places they would be amply rewarded later in the renewed appreciation of the amenities of the larger communities and hospitals to which they tend to flock.

Last winter, tragedy struck in one of the far-north communities when Mildred Venning Rundle, one of the best qualified and most experienced nurses in the Arctic, was killed when the roof of a warehouse collapsed. The gap created by her passing after 20 years of active service cannot be filled

by young, inexperienced new graduates. It serves, rather, to emphasize the need that exists for many, many more trained minds and hands to pick up the threads of service thus broken.

Just supposing Miss 1953 Graduate was interested in offering her abilities in one of the more sparsely settled areas, how would she go about it? To whom would she write for information? Are there any limitations or requirements she should know about? Does she have to learn Eskimo or Indian dialects before she can be employed? Would she have to work all alone in these places?

There are several avenues she can follow, any one of which would lead to rich experiences in nursing. First, the Canadian Red Cross Society has an extensive network of Outpost Hospitals in virtually every province. There, nurses live and work in comfortably equipped, small hospitals with a housekeeper provided to look after the meal-getting and kindred details. Full information is available on request. Write to the *National Director, Nursing Services, Canadian Red Cross, 95 Wellesley St., Toronto 5, Ontario.*

Newfoundland and Alberta have a slightly different pattern with services organized under their respective Departments of Health. The Cottage Hospital we visited in Newfoundland last year would be a fine place to work. Nurses from the mainland would enjoy the experience offered in these units in an environment so different from their own. The Department in St. John's would welcome sincere inquiries. Alberta, too, provides comfortable living quarters for the nurses who go to the frontier posts.

Fairly new in name but old in the service it gives is the Indian Health Services organized by the Federal Government. The recently appointed director, Miss Alice Smith, will give an inquirer full information on the far-flung opportunities available.

Last, but by no means least, is the privilege of service under the auspices that Mildred Rundle chose — the Missionary Societies of our leading denominations. Nurses may secure the names and addresses of the responsible authorities to whom to write through their own church affiliation.

The tragic loss of an experienced nurse-missionary, at the very peak of her usefulness, is a clarion call to young nurses to think very seriously of themselves as recruits in the battle against ignorance and disease in those distant parts of our land. Who will seize the glowing torch of service and by its light bring knowledge and health to those in need?

Advice to the Lank and Lean

Some are born fat, some achieve fatness, and some have fatness thrust upon them — likewise with thinness, advises Dr. Harold V. Cranfield, Toronto specialist in physical medicine.

"The thin are so for want of muscle and this in turn is due to lack of healthy appetite," he notes. "Eating alone is not the cure, however, for it takes hard work to build muscle. Weight gain that is not predominantly muscular gain would not be the goal of the bony. It requires a special form of hard work, something in the nature of weight-lifting, to build healthy additional tissue — and this is only for those who have been pronounced physically fit for indulgences of such vigor. In general, it is out of reach of those past 40. They must be content with the knowledge that they are, all else being equal, in a preferred risk status with insurance companies."

Dr. Cranfield points out that every square millimeter of muscle tissue comprises 1,000 muscle fibres and 2,000 blood vessels. "One cannot increase the number of muscle fibres but their quality can be improved. Many of the fibres are thin and pale in individuals who are thin and pale."

Hard work, perseverance, and a menu that includes plenty of meat are the price of a solid gain in weight.

— *Health News Service*

Treatment of Burns

A. W. Farmer, M.D.

This article deals with the treatment of thermal burns under such circumstances as are envisaged following an atomic explosion. Combinations of various types of injury will occur but it is likely that casualties due to heat will exceed all others in number. Although circumstances, such as the season of the year, the number of casualties, availability of supplies, functioning of ancillary services, etc., will undoubtedly modify what can be accomplished, forward planning is necessary. Levels of casualty service are:

1. *Disaster area* in which treatment is to be delivered by first aiders only.
2. *First aid stations* where the injured *may* be held for 24 hours and where doctors, nurses, first aiders, etc., are available.
3. *Emergency hospitals* in most of which the set-up will allow only simple laboratory determinations to be made.

The treatment advised at these levels is outlined. Nothing new is brought forth. The therapy of burns at the first and second levels *is to be* empirical, and at these levels neither time nor facilities will allow personnel to indulge individual preferences in their handling of patients. Specialists are to be located at the third level where facilities *may* exist that will permit modifications of therapy to fit individual needs.

Within broad limits, the clinical course of a burned person can be foretold. On the whole, troubles are likely to arise due to a number of factors, that may be observed immediately the patient is seen. The important items are four in number. For the planning of therapy observation of these must be recorded and the margin of error should not be too great.

Dr. Farmer is assistant professor, Department of Surgery, University of Toronto. This article is the third of a series to be reprinted, with permission, from the special issue for Civil Defence, published by the *Canadian Medical Association Journal*.

The extent of the area burned compared to the total body area. Fig. 1 shows a simple method of reckoning this. This does not give an accurate computation as there is much variation among individuals and particularly between small children and adults. A rapid estimation without a large margin of error is the aim.

Fig. 2 shows, in a rough fashion, the relationship of the extent of the burn to the mortality. It is noted that the mortality rises steeply, when over one-third of the surface is involved. Not many patients survive with deep burns of one-half of the body surface.

The age of the patient. Frail and aged persons have a poor prognosis. *Fig. 3* shows, in a rough fashion, the effect of age on mortality for burns of different extent. Under emergency circumstances, it can be expected that these mortality rates will be much higher. This knowledge may be valuable if it is necessary to practise triage.

The depth of the burn. Except for

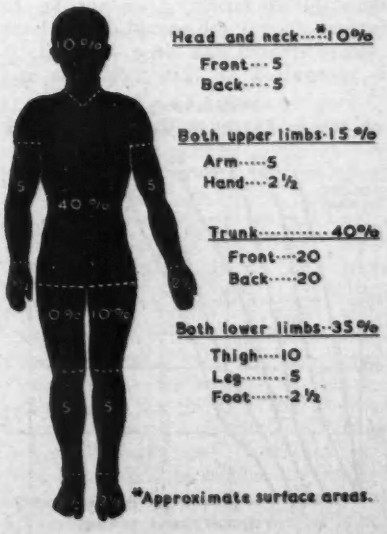

Fig. 1

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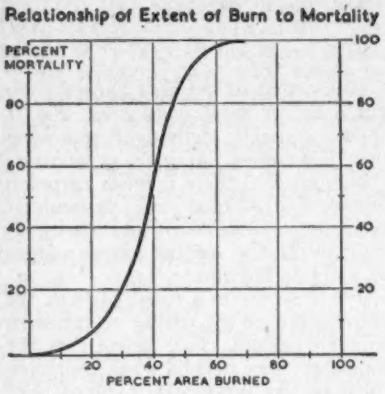

Fig. 2

very superficial damage, this is a difficult factor to estimate accurately. The uninitiated usually believe the damage to be more superficial than is the fact. For purposes of notation, the depth of burn may be described as first, second, or third degree (see *Fig. 4*). The first degree is damage to the epidermis and is recognized as an erythema which is followed later by superficial scaling. The second degree is damage to the dermis. The dermis being much thicker than the epidermis, it is possible to further classify the second degree burn into superficial and deep varieties. It is recognized by bleb formation and

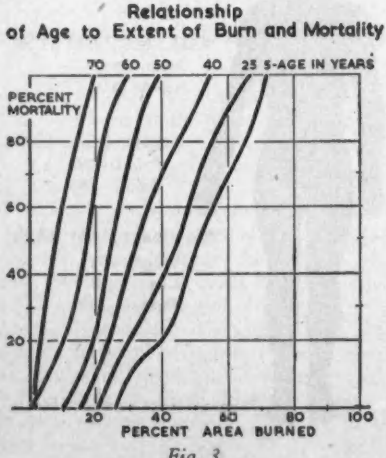

Fig. 3

in the case of deeper second degree burns by a "cooked" appearance of the surface. The deep second degree burns are extremely difficult to differentiate from the third degree burns which include those in which the damage extends completely through the skin into the deeper tissues. In these, there is sometimes a "cooked" appearance and sometimes the surface is charred.

The first degree burn is not of great clinical consequence and is accordingly left out of the estimate of area burned. The superficial second degree burns heal rapidly (5 to 14 days) and leave little scarring. The deep second degree burns heal slowly with much scarring. The third degree burn, if large, requires skin replacement. Sometimes the deep second degree variety is more suitably treated by skin replacement also. It is the deep second and third degree burns that need prolonged hospitalization and present serious problems for late treatment. For this reason, an attempt should be made when the damage is first viewed to distinguish between a shallow and a deep burn, so that segregation and disposal of patients will be facilitated.

Combined injury. The combination of burns and other trauma (radiation, crush injury, fractures, etc.) raises mortality and morbidity rates considerably. This must be taken into account, if triage is practised, either to signify the uselessness of therapy for some patients or the urgency of therapy for others.

A measure of the above factors allows a fairly accurate estimate to be made of the prognosis concerning both mortality and morbidity. It also gives most of the data from which is translated the urgency, quantity, and quality of early general therapy.

In addition to the above factors, it should be appreciated that a burn causes a wound from which noxious substances are absorbed. These may be from the burned tissue and from anything that comes into contact with this particular variety of wound. Therefore, in any planning for local therapy (be it open or closed), care must be taken not to exhibit to this

wound, materials which are damaging either locally, or by virtue of absorption, generally.

With the above preamble, the following is advised for the treatment of mass burn casualties at the levels noted above.

First Aid in the Disaster Area

At this level first aiders are equipped to give drugs for the relief of pain and to apply dressings. If the patient is unable to walk, transport will be available. Variable weather conditions (winter or summer) may affect treatment at this level.

The first aiders are to use drugs for the relief of pain sparingly. If morphine in syrettes is available, it should be used chiefly for persons with combination (fractures, etc.) injuries. The full dose (¼ gr.) should only be given to adults. For children the dose should be scaled down in proportion to weight. Large doses abet the harmful anoxia which accompanies the secondary shock of severe burns. Other drugs, such as the barbiturates, should be substituted whenever possible. An individual with a small burn (under 10%) and who can walk can be left without special dressing and directed to the first aid station. If the burned area is extensive, first aiders should place a sheet or other clean covering on the stretcher, put the patient on it and wrap the remainder of the covering around him. Clothing should be loosened but not removed.

First Aid Station

Professional personnel will be present at this level and the burn should be inspected by a physician. A gentle debridement of the surface may be performed with removal of gross dirt and the wiping away of loose epithelium. The burned area (with the exception of face and genitals) should be covered with the burn dressing pads provided. These should be bandaged into position. The dressing materials have been standardized. The pads are of two sizes and have an inside surface of fine mesh gauze, a layer of compressible absorptive cotton, a layer of cellulose wadding, and an outside wet repellant

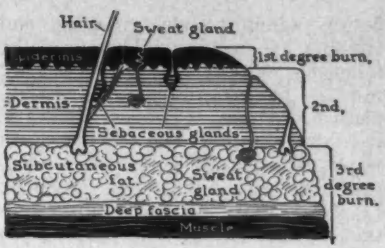

Fig. 4

covering. The bandages have little elasticity but the dressing is to be applied as an occlusive pressure dressing, extending well beyond the burn area and held by firmly applied bandages. On the outside, the individual who performs the dressing draws the approximate outline of the burn area with a wax pencil. This is to include the second and third degree burn only. An estimate of whether it is shallow or deep is also marked on the dressing cover.

The patient is to be encouraged to take fluids. Sedative is given intravenously, hypodermically, or by mouth, as indicated.

The percentage of the total body surface as pictured on the surface of the dressing is calculated *(Fig. 1)* and recorded. If this is 10 per cent or greater, general therapy is commenced. Amounts of intravenous fluid therapy are given according to the following formula for the first 24-hour period: 4 cc. of blood substitute for each per cent of burned surface for each *ten* pounds of body weight, plus an equal amount of isotomic saline, plus an equal amount of 5% dextrose in water. When first seen, if the patient is in obvious secondary shock (fast heart beat, clammy slate gray extremities with a slow return of color after blanching by digital pressure, irrational or semi-comatose), the intravenous fluids therapy is to be expedited and one-third of the 24-hour volume of blood substitute should be delivered within one hour. Pressure may be applied to hasten the rate of intake or more than one intravenous apparatus may be started. Blood is not likely to be available at this level and

before administration grouping and crossing are required. Therefore, the following in order of preference are used — plasma, reconstituted serum, plasma volume expander, dextrose in saline, saline and dextrose in water. The plasma volume expanders provided are polyvinylpyrrolidone (P.V.P.) and a polysaccharide (dextran or macrodex). The fluids given and amounts of each are to be recorded. Tests to establish more accurately the fluid replacement requirements are not likely to be available at this level and under no circumstances should treatment be delayed for the development of clinical signs of secondary shock. If the patient will take oral fluids, water may be given if the following solution is not available — one quart of water to which is added a level teaspoon of salt and a half a level teaspoon of bicarbonate of soda.

At the level of first aid stations, the main effort in the treatment of the burn casualty is fluid replacement. While substitutes for blood are used, it must not be forgotten that they have no oxygen carrying capacity. Many patients would be better with some blood and particularly those with extensive deep burns.

Antibiotics are to be used prophylactically if they are in plentiful supply. Otherwise they are to be reserved for the patients with extensive burns and particularly those with extensive deep burns and combined injuries. Penicillin is given intramuscularly in a single daily dose of 400,000 units (300,000 units of procaine penicillin plus 100,000 units of crystalline penicillin per cc. as supplied). Concomitantly in extensive deep burns or those with severe combination injuries, one may give streptomycin, 0.5 gm. intramuscularly twice a day, or one of the broad spectrum antibiotics (aureomycin or terramycin), 250 mg. by mouth four times a day.

Except for the very young or aged, the patients with less than 15 per cent burns may be allowed up and are to be encouraged to help with their evacuation to the emergency hospitals. Priority for transfer should be given to the seriously injured.

Emergency Hospitals

Patients should be arriving at the emergency hospitals within 24 hours. Those who remain at first aid stations have their treatment continued at that point (until evacuation) as outlined for the emergency hospitals.

The general condition of the patient is the first consideration. Fluid intake and urinary output are to be recorded. All patients with over 25% burns (and those over 60 years with over 15% burns) are to have an indwelling catheter for five days so that output can be accurately measured. Except in infants, the output should be at least 25 cc. an hour. If the output is small as the result of inadequate intake, a significant increase should be obtained by 5 cc. per pound body weight of 5% dextrose and water given over a two-hour period. Inability of the kidneys to function should be considered if the response is not apparent. In such a case, salt is restricted and only enough fluid is given to replace the insensible loss through the skin and lungs.

It is not likely that tests requiring specially trained technicians or intricate apparatus will be available in the emergency hospitals. However, hemoglobin estimations, blood counts and smears, and urinalysis will be possible so that some guide can be obtained for continued intravenous therapy. If it is necessary to treat empirically, approximately one-half (more in small children) of the first 24-hour fluid requirements should be adequate for the second day. The intravenous fluid therapy should be continued until the patient has an adequate oral intake. This is usually so at the end of the second day for those with burns of 20% or less. Intravenous therapy may be necessary as a supplement for many days in the more severely burned. For the latter, there should be available good laboratory facilities, either by transport of specimens or the patient.

The problem of fluid replacement being under control, decision for definitive local therapy must be made. The local application having been made at the first aid station, inspection of the area may be indicated at the emergency hospital level. Those dressings

marked "shallow" may be removed and the areas left open for plasma clot formation, or redressed if it is considered that the original guess was in error. Those dressings marked "deep" may be inspected when warranted by the patient's general condition. Such patients should be transferred within ten days to hospitals equipped for surgical procedures. The first redressing (other than noted above) is performed in ten days, unless the condition of the patient or the dressing indicates earlier redressing. The patient may be running an unexplained swinging fever with copious discharge from the wound or the dressing may be moist and foul. Dressings which become soaked through should be changed if possible. They become the breeding place for mixtures of organisms.

Secondary anemia of severe degree develops rapidly in severely burned patients. Laboratory tests will give indication of this and the patient should be protected by blood transfusions and placed on daily doses of iron. The nutritional state will deteriorate rapidly with extensive third degree burns, the weight loss becoming readily apparent within 7 to 14 days. To forestall this, high caloric, high protein diets are enforced. If these are refused, additional feedings can be given via duodenal tube as a continuous drip. Diets are to be vitamin supplemented.

The prophylactic antibiotic therapy which was commenced at the first aid station is to be continued. Wherever possible in cases in which infection is considered a factor of importance, cultures should be taken in order to obtain knowledge of the susceptibility of the various organisms against the antibiotics available. The local application of the antibiotics may be indicated. The usefulness of the sulfonamides (sulfadiazine will be available) should not be forgotten.

The indications for such drugs as adrenocorticotrophic hormone, cortisone, adrenocortical extract, growth hormones, etc., are not clear enough to warrant their use. Actual harm may be caused by them, particularly if the timing in their employment is wrong. It is accordingly advised that there is no place for such drugs in the treatment of mass burn casualties at the present time.

The preparation for grafting of an area of deep burn damage is important. Small deep burns may be excised. The area may be grafted immediately or such area may be left undisturbed for a few days until a thin layer of granulation tissue has formed and then grafted. If facilities are adequate, larger areas may be treated in this manner also. The sequestration of dead tissue from a larger area usually takes place in 18 to 21 days. It can be hastened by chemical and enzymatic agents. At this time, such agents as are in general employment are not startling in their effect and present considerable trouble in their use. For the treatment of mass casualties, they will, therefore, not be stocked at present. Sodium hypochlorite in a hypertonic solution applied on dressings is useful (Dakin's solution, eusol, hygeol). The dressings should be kept moist and changed at least daily. Baths would be of use at this stage but require special apparatus and trained assistants.

Early grafting is lifesaving for patients with extensive deep burns. At present the only place for homografts is their use as a temporary covering. Occasionally this is indicated. All patients will eventually require recovering with their own skin. Thin (ten-thousandths of an inch) partial thickness skin grafts are used in most instances for larger areas. Any detailed discussion of this phase of therapy is beyond the scope of this article.

In conclusion, burns are expected to be the major problem in therapy if and when atomic bombing of large cities happens. The number of individuals with combination injuries will add greatly to mortality and morbidity rates and to the difficulties encountered in therapy. The treatment of mass casualties must be as simple as possible, compatible with the circumstances.

Traitement des Brûlures

A. W. Farmer, M.D.

Cet article porte sur le traitement des brûlures d'origine thermique dans les circonstances qui, selon les prévisions, prévaudront à la suite d'une explosion atomique. Il se rencontre des associations de divers types de blessures, mais il est probable que l'onde de chaleur fera beaucoup plus de victimes que toutes les autres causes. Bien que diverses circonstances telles que la saison de l'année, le nombre des victimes, la disponibilité des fournitures de traitement, le bon fonctionnement des services auxiliaires, etc., influeront sans aucun doute sur ce qui pourra s'accomplir, il est nécessaire de faire des préparatifs à l'avance.

En résumé, le service du soin des victimes se répartira entre les trois échelons ci-dessous:

1. *Dans l'étendue du désastre,* où le traitement ne sera donné que par les secouristes.

2. *Aux postes de secourisme,* où le blessé *pourra* être gardé 24 heures et où seront en service des médecins, des infirmières, des secouristes, etc.

3. *Aux hôpitaux improvisés,* dont l'aménagement, dans la plupart des cas, ne permettra d'effectuer que des examens rudimentaires de laboratoire.

Le traitement recommandé à ces échelons est exposé plus loin. Il ne comporte rien de nouveau. Au premier et au second échelon, le traitement des brûlures *doit être* empirique, car, à ces échelons, le personnel n'aura ni le temps ni les moyens d'appliquer ses méthodes préférées au traitement de ses malades. Des spécialistes seront en service au troisième échelon, où existeront *peut-être* les aménagements voulus pour adapter le traitement aux besoins de chaque individu.

Il est possible de prévoir en grande partie l'évolution clinique de chaque cas de brûlure. A tout prendre, des troubles se produiront vraisemblablement en raison de plusieurs facteurs, que l'on peut observer dès que l'on est en présence du malade. Les points importants sont au nombre de quatre. Pour dresser le plan de traitement, il faut prendre note de ces quatre types d'observations, et ainsi la marge d'erreur ne devrait pas être trop grande.

L'étendue de la surface brûlée, par rapport à la superficie globale du corps. La *Fig. 1* (p. 605) donne un moyen simple d'effectuer ce calcul. Elle ne fournit pas de données exactes, car la variation est grande entre les individus, en particulier entre les enfants en bas âge et les adultes. Il s'agit donc de faire une estimation rapide sans une grande marge d'erreur.

La *Fig. 2* (p. 606) illustre sommairement le rapport entre l'étendue des brûlures et le taux de mortalité. On remarquera que ce taux monte brusquement lorsque plus d'un tiers de la surface cutanée est en cause. Peu de malades survivent à des brûlures profondes de la moitié de la surface du corps.

L'âge du malade—Le pronostic est sombre dans le cas des personnes frêles ou âgées. La *Fig. 3* (p. 606) illustre sommairement l'influence de l'âge sur le taux de mortalité pour des brûlures d'étendue différente. Dans des circonstances critiques, on peut s'attendre que ces taux de mortalité soient beaucoup plus élevés. Il peut être utile de connaître cette particularité, au cas où il serait nécessaire de faire un triage.

La profondeur des brûlures—Exception faite des atteintes très superficielles, cette estimation est difficile à faire avec exactitude. Ceux qui ont peu d'expérience dans ce domaine sont portés à croire les brûlures plus superficielles qu'elles ne le sont en réalité.

Le Dr. Farmer est professeur adjoint de chirurgie à l'université de Toronto. Ceci est le troisième d'une série d'articles du numéro spécial du *Canadian Medical Association Journal* sur la Défense Civile qui sont publiés avec la permission de l'Association Médicale Canadienne.

Aux fins d'inscription, la profondeur d'une brûlure peut être décrite comme étant du premier, du deuxième, ou du troisième degré (voir la *Fig. 4*, p. 607). Au premier degré, seul l'épiderme est atteint, ce qui se reconnaît sous forme d'un érythème auquel fait suite une desquamation superficielle. Au deuxième degré, la brûlure atteint le derme. Ce dernier étant beaucoup plus épais que l'épiderme, il est possible de subdiviser les brûlures du deuxième degré en types superficiel et profond. Ce genre de brûlures se reconnaît à la formation de cloques et, dans le cas des brûlures profondes du deuxième degré, à une apparence "cuite" de la surface. Les brûlures profondes du deuxième degré sont extrêmement difficiles à distinguer des brûlures du troisième degré, qui comprennent celles qui ont complètement traversé la peau pour atteindre les tissus profonds. Dans ce cas, la surface apparaît parfois "cuite" et parfois carbonisée. Les brûlures du premier degré n'ont pas beaucoup d'importance clinique — c'est pourquoi on n'en tient pas compte dans l'estimation de l'étendue brûlée. Les brûlures superficielles du deuxième degré guérissent rapidement (en cinq à 14 jours) et ne laissent que peu de cicatrices. Les brûlures profondes du deuxième degré guérissent lentement en laissant des cicatrices prononcées. Les brûlures du troisième degré, si elles sont étendues, exigent des greffes cutanées. Parfois, les brûlures du deuxième degré de type profond, elles aussi, se traitent mieux par des greffes. Ce sont les brûlures profondes du deuxième et du troisième degré qui exigent un séjour prolongé à l'hôpital et posent de sérieux problèmes à l'égard de la continuation du traitement. C'est pourquoi on doit s'efforcer, lors du premier examen, de distinguer entre les brûlures superficielles et les profondes, afin de faciliter la tâche de trier les malades et de décider ce qu'on doit en faire.

Brûlures associées à des blessures— L'association de brûlures à d'autres traumatismes (radiations, écrasements, fractures, etc.) contribue à accroître fortement les taux de mortalité et de morbidité. Il faut en tenir compte, si l'on effectue un triage, pour déterminer soit l'inutilité de tout traitement dans le cas de certains malades, soit l'urgence d'en soigner d'autres.

Ces considérations, si l'on en tient raisonnablement compte, permettront de déterminer le pronostic avec assez d'exactitude, tant du point de vue de la mortalité que de celui de la morbidité. Elles fournissent aussi la plupart des données d'où l'on déduit l'urgence, la quantité et la qualité du traitement général précoce à instituer.

En plus des observations exposées ci-haut, il faut reconnaître que toute brûlure cause une plaie d'où peuvent s'absorber des substances toxiques. Celles-ci peuvent provenir des tissus brûlés et de tout ce qui vient en contact avec cette variété particulière de plaies. C'est pourquoi, en appliquant un traitement local (que la plaie soit ouverte ou non), il faut prendre soin de ne pas exposer cette plaie à des substances qui puissent aggraver le mal soit localement, soit généralement par absorption.

Après ce préambule, les recommandations suivantes s'imposent au sujet du traitement d'un grand nombre de victimes atteintes de brûlures, aux échelons précités.

Secourisme dans la Zone du Desastre

A cet échelon, les secouristes sont porteurs d'une trousse qui leur permet d'administrer des calmants et de faire des pansements. Si le malade est incapable de marcher, il y aura des moyens de transport à sa disposition. Les conditions variables de la température (hiver ou été) peuvent influer sur le traitement à cet échelon.

Les secouristes ne doivent administrer de calmants pour soulager la douleur, qu'avec modération. S'ils ont de la morphine en syrettes, ils doivent la réserver surtout aux personnes atteintes de blessures associées (fractures, etc.). La pleine dose (¼ gr.) ne doit être administrée qu'aux adultes, tandis que, dans le cas des enfants, la dose doit être proportionnée à leur poids. Les fortes doses favorisent le dangereux manque d'oxygène qui accompagne le choc secondaire des brûlures graves. D'autres drogues que la mor-

phine, par exemple les barbiturates, doivent lui être substituées autant que possible. Dans le cas d'un particulier présentant une petite brûlure (de moins de 10 p. 100) et pouvant marcher, on peut le laisser sans pansement spécial et le diriger vers le poste de secourisme. Si la surface brûlée est de grande étendue, les secouristes devraient étendre un drap ou autre couverture propre sur le brancard, y faire coucher la victime et envelopper celle-ci des pans de la couverture. Il faut relâcher les vêtements sans les enlever.

Au Poste de Secourisme

A cet échelon, il y aura en service du personnel professionnel et la brûlure devrait être examinée par un médecin. On peut effectuer un léger débridement de la surface pour enlever des saletés évidentes et essuyer l'épithélium détaché. La surface brûlée (à l'exception du visage et des parties génitales) doit être recouverte avec des pansements préparés à cet effet. Il faut solidement assujettir ces pansements. Le matériel de pansement a été normalisé. Les tampons sont de deux grandeurs et sont formés d'une couche intérieure en gaze à trame serrée, d'une couche compressible de coton hydrophile, d'une couche cellulosique de rembourrage et d'un revêtement extérieur hydrofuge. Les bandages sont peu élastiques mais les pansements sont destinés à être appliqués comme recouvrements de pression, s'étendant bien au delà des limites des brûlures et solidement assujettis au moyen de bandages. Sur la surface extérieure du pansement, la personne qui l'applique tracera avec un crayon de cire les contours des brûlures. Toutefois, cette pratique ne doit s'appliquer qu'aux brûlures du deuxième et du troisième degrés. Sur le dos du pansement, on indiquera aussi si la brûlure semble superficielle ou profonde.

On incitera le blessé à boire beaucoup de liquides. On donnera des calmants par injection intraveineuse, hypodermique ou par voie orale, selon les indications.

On notera l'étendue de la brûlure dont les contours sont dessinés sur le pansement pour calculer ensuite et inscrire le pourcentage de la surface totale du corps (*Fig. 1*, p. 605). Si ce pourcentage est de 10 p. 100 ou davantage, on entreprendra le traitement général. Celui-ci comportera l'injection intraveineuse de grandes quantités de liquides selon la formule ci-dessous, durant les premières 24 heures: 4 cc. d'un succédané du sang pour chaque unité procentuelle de la superficie brûlée pour chaque *dix* livres de poids corporel, plus une égale quantité de sérum physiologique, plus une égale quantité de sérum glucosique à 5 p. 100. Dès le premier examen, si le blessé est dans un état évident de choc secondaire (pouls rapide, extrémités moites et d'un gris d'ardoise qui réapparaît après avoir pâli par pression du doigt, délire ou état semi-comateux), la sérothérapie doit être accélérée, de façon qu'un tiers du volume du succédané du sang prévu pour 24 heures soit administré en une heure. Pour hâter l'absorption, on peut, soit appliquer une certaine pression, soit utiliser plus d'un appareil d'injection intraveineuse. Il est peu probable qu'on ait du sang entier à sa disposition à cet échelon et, en outre, son administration exige des déterminations de groupes sanguins et des épreuves de compatibilité. C'est pourquoi on emploie les produits suivants, par ordre de préférence: plasma, sérum reconstitué, diluant de plasma, sérum physiologique glucosé, sérum physiologique et sérum glucosique. Les diluants de plasma qui sont fournis sont la polyvinylpyrrolidone (P.V.P.) et un polysaccharide (dextran ou macrodex). On inscrira toujours les quantités de liquides injectées. Il est peu probable qu'à cet échelon puissent s'effectuer des épreuves pour déterminer avec plus d'exactitude les besoins en liquides de remplacement et pour aucune considération il ne faut attendre que des signes cliniques de choc secondaire se manifestent pour instituer le traitement. Si le blessé est capable d'absorber des liquides oralement, on peut lui donner de l'eau si l'on n'a pas sous la main la solution suivante: une pinte d'eau additionnée d'une cuillerée à thé rase de sel et d'une demi-cuillerée à thé rase de bicarbonate de soude.

A l'échelon des postes de secouris-

me, il faut surtout s'efforcer, dans le traitement des victimes atteintes de brûlures, d'effectuer des transfusions. Bien qu'on y emploie des succédanés du sang, il ne faut pas oublier qu'ils sont dépourvus de toute aptitude à transporter de l'oxygène. Nombre de blessés auraient avantage à recevoir une transfusion de sang, en particulier ceux dont les brûlures sont étendues.

On emploiera les antibiotiques en prophylaxie, si l'on en a d'abondantes provisions. Sinon, on les réservera aux grands brûlés, en particulier à ceux qui sont atteints de grandes brûlures profondes accompagnées d'autres blessures. La pénicilline se donne par injection intramusculaire en doses quotidiennes de 400,000 unités (300,000 unités de pénicilline procaïnique avec 100,000 unités de pénicilline cristallisée par ml., telles qu'elles sont fournies). Dans les cas de grandes brûlures profondes ou de celles qui sont accompagnées de blessures graves, on peut administrer en même temps de la streptomycine en doses intramusculaires de 0.5 gm. deux fois par jour ou l'un des antibiotiques au spectre étendu (auréomycine ou terramycine), à raison de 250 mg. par la bouche quatre fois par jour.

Sauf dans le cas des brûlés très jeunes ou âgés, on peut permettre de se lever à ceux dont les brûlures couvrent moins de 15 pour cent de la surface corporelle et ils doivent être engagés à aider à leur évacuation sur les hôpitaux improvisés. Il faut accorder la priorité aux brûlés gravement atteints dans le transfert aux hôpitaux improvisés.

Aux Hopitaux Improvises

Les malades devraient arriver aux hôpitaux improvisés dans les 24 heures. Ceux qui restent aux postes de secourisme y poursuivent leur traitement (jusqu'à leur évacuation) de la façon exposée pour les hôpitaux improvisés.

L'état général du malade est la considération primordiale. On prendra note de l'ingestion de liquides et du volume des urines. Tous les blessés atteints de brûlures de plus de 25 p. 100 (et ceux de plus de 60 ans qui sont atteints de brûlures de 15 p. 100) doivent être pourvus d'un cathéter installé à demeure pour cinq jours, afin de mesurer avec exactitude le débit urinaire. Sauf dans le cas des enfants en bas âges, ce débit doit être d'au moins 25 cc. par heure. Si le débit est faible par suite d'une ingestion insuffisante de liquides, on devrait obtenir un accroissement notable en administrant durant une période de deux heures 5 cc. par livre de poids corporel de sérum glucosique à 5 p. 100. S'il ne se produit pas de réaction apparente, il faudra présumer que les reins ne sont peut-être pas en état de fonctionner. Dans ce cas, on restreindra la consommation de sel et on ne laissera le malade absorber que suffisamment de liquide pour remplacer la perte insensible qui se fait par la peau et les poumons.

Il est peu probable que les hôpitaux improvisés puissent offrir les épreuves qui exigent des techniciens spécialisés ou des appareils complexes. Toutefois, on pourra y obtenir des déterminations de l'hémoglobine, des frottis et des numérations des globules du sang, ainsi que des analyses d'urine, qui pourront servir de guides dans la poursuite du traitement intraveineux. S'il est nécessaire d'appliquer un traitement empirique, à peu près la moitié (davantage dans le cas des enfants en bas âge), des quantités de liquide requises durant les premières 24 heures devrait suffire le deuxième jour. Le traitement par injection intraveineuse de liquide doit se poursuivre jusqu'à ce que le malade puisse absorber suffisamment de liquide par la bouche. C'est ce qui se produit habituellement à la fin de la deuxième journée dans le cas des brûlures à 20 p. 100 ou moins. La sérothérapie intraveineuse peut être nécessaire comme supplément durant plusieurs jours, dans le cas des grands brûlés. Pour ces derniers, on devrait avoir à sa disposition de bonnes facilités de laboratoire soit par transport des spécimens, soit par évacuation des malades.

Le problème du remplacement des liquides étant résolu, il reste à décider quel traitement local appliquer en définitive. L'application locale ayant été exécutée au poste de secourisme, il peut être opportun d'examiner la brû-

lure, à l'échelon de l'hôpital improvisé. Les pansements marqués "superficiels" peuvent être enlevés et les surfaces brûlées, laissées à découvert pour faciliter la coagulation du plasma, ou bien les plaies peuvent être pansées de frais si l'on juge que l'indication sur la profondeur de la brûlure est erronée. Les pansements marqués "profonds" peuvent être examinés lorsque l'état général du malade l'exige. Ces malades doivent être transférés en moins de dix jours à des hôpitaux ayant les installations de chirurgie voulues. Le premier changement de pansement (à part le cas mentionné ci-haut) s'exécutera dix jours plus tard, à moins que l'état du malade ou du pansement ne réclame ce changement plus tôt. Le malade peut faire une fièvre inexpliquée, avec des hauts et des bas, avec suppuration abondante de la plaie, ou bien le pansement peut être imbibé ou déplacé. Si possible, il faut changer les pansements qui deviennent imprégnés, car ils deviennent de bons milieux de croissance pour une foule d'organismes.

Une anémie secondaire grave se produit rapidement chez les grands brûlés. Les épreuves de laboratoire en donneront le signal, il faudra alors y parer au moyen de transfusions de sang et administrer au malade des doses quotidiennes de fer. L'état de nutrition se détériorera rapidement chez les personnes atteintes de brûlures étendues du troisième degré, l'amaigrissement devenant manifeste en sept à 14 jours. Pour y parer, il faut imposer au malade un régime alimentaire riche en calories et en protéines. S'il refuse ce régime, on peut lui procurer un supplément de nourriture par l'entremise d'un tube duodénal, sous forme d'instillation continue. Il est bon d'ajouter au régime alimentaire des suppléments vitaminiques.

L'antibiothérapie prophylactique qui a été instituée au poste de secourisme doit être poursuivie. Autant que possible dans les cas où le danger d'infection est jugé important, il faut prélever des spécimens de culture en vue de déterminer si les divers organismes trouvés dans la plaie sont vulnérables aux antibiotiques dont on dispose. L'application locale des antibiotiques peut être indiquée. Il ne faut pas oublier l'utilité des sulfamidés (on aura de la sulfadiazine à sa disposition).

Les conditions qui militent en faveur du recours à des médicaments tels que l'hormone adrénocorticotrope, la cortisone, l'extrait adrénocortical, les hormones de croissance, etc., ne sont pas assez bien connues pour en justifier l'emploi. De fait, ils peuvent être plutôt dommageables, en particulier s'ils ne sont pas administrés au bon moment. C'est pourquoi l'opinion générale est qu'il n'y a pas lieu d'employer ces médicaments dans le traitement en masse de victimes atteintes de brûlures, pour le moment.

La préparation des brûlures profondes pour la greffe a de l'importance. Les petites brûlures profondes peuvent être enlevées au bistouri. On peut procéder immédiatement à la greffe ou bien laisser la plaie telle quelle pour quelques jours jusqu'à l'apparition d'une mince couche de granulations, alors qu'on effectue la greffe. Si l'on en a les commodités voulues, on peut aussi traiter les grandes brûlures de cette façon. La séquestration des tissus nécrosés d'une grande brûlure s'effectue habituellement en 18 à 21 jours. Il est possible de l'accélérer au moyen d'agents chimiques et enzymotiques. Pour le moment, les agents couramment employés n'ont pas d'effets sensationnels, mais par contre leur emploi comporte beaucoup de difficultés. Pour le traitement en masse des victimes, par conséquent, on n'en constituera pas de réserves. L'application d'une solution hypertonique d'hypochlorite de sodium sur les pansements est utile (solution de Dakin, eusol, hygéol). Les pansements doivent être maintenus humides et être changés au moins chaque jour. Des bains seraient utiles à ce moment mais ils exigent des appareils spéciaux et des assistants entraînés.

La greffe précoce est un gage de survie pour les malades atteints de brûlures profondes étendues. A l'heure actuelle, les greffes homoplastiques ne sont recommandées que comme revêtements provisoires. Il se rencontre des cas où cette opération est indiquée. Tous les brûlés auront éventuellement besoin de recouvrir leurs plaies avec

leur propre épiderme. On emploie de minces couches (dix-millièmes de pouce) partielles de l'épiderme comme greffes dans la plupart des cas de brûlures étendues. Il n'entre pas dans le cadre de cet article d'exposer en détail cette phase du traitement.

En somme, on prévoit que les brûlures constitueront le principal problème de traitement dans le cas du bombardement atomique des grandes villes. Le grand nombre de personnes atteintes de blessures associées contribuera largement à accroître les taux de mortalité et de morbidité, ainsi que les difficultés qui se rencontrent au cours du traitement. Les soins à donner à de nombreuses victimes doivent être aussi simples que possible et convenir aux circonstances. Dans une telle occasion, les conseils exposés ci-haut peuvent être utiles.

Chronic Ulcerative Colitis

JOHN A. MACLEOD, M.D.

THIS IS A CONDITION the management of which has been a baffling problem to medical science for a long time. Here, though (as in so many other fields of medicine), important advances have been made in recent years. The present review of the subject may be made under a few appropriate headings.

ETIOLOGY

This is still unknown. Various bacteria have been blamed, such as Bargen's diplostreptococcus and dysentery bacilli, as have also allergic states — that is, the reaction of the bowel to ingestion of something to which it is allergic. While the mechanism of its production is not proved, we do know that it occurs chiefly in neurotic young females — those emotionally unstable individuals who are unable to adapt themselves or make the necessary adjustments when they find things are not going exactly as they had expected or wished. Instead of meeting their problems with resolution and resourcefulness, these individuals develop chronic ulcerative colitis. In loftier terms, then, it has been said that this condition is an abnormal response to stress initiated by an excessive reaction to a life situation.

How do these psychic or emotional stimuli get through to the colon? The answer to that one, as far as I know, has not yet been put accurately in words. The "nervous" puppy and the nervous student at examination time, though, are familiar to most of us. Somehow, possibly in the region of the hypothalamus, stimuli emanating from the cerebral cortex spill over into the vagus nerve. This nerve is motor to the musculature of the alimentary tract and also secretomotor and vasomotor to it. It is suggested that due to vasoconstriction (caused by nerve impulses acting directly on the vessels) or, in the case of the colon, due to overactivity of the musculature of the bowel pinching the vessels as they pass through that musculature (or a combination of these two possibilities), the blood supply to the mucous membrane is reduced, causing hypoxia or anoxia of that mucous membrane. This anoxia devitalizes some of the cells of the mucous membrane so that these break down and erosions appear. Once the ulcers are formed, various bacteria can get into them and contribute their share to the destruction, which may progress either slowly or at a fearsome speed (it varies tremendously from one case to another).

SYMPTOMS AND SIGNS

The most obvious symptom is diarrhea — loose, highly offensive stools containing mucus, and sometimes pus and blood. The condition may begin insidiously with gradually increasing looseness of the bowels, or it may be fulminant, with diarrhea accompanied

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by severe abdominal cramps, high fever, and toxemia. Often there is troublesome tenesmus. Various other symptoms could be described, depending on just what systemic effects are produced or what complications develop.

The systemic effects observed in this condition depend upon the following facts:

1. Protein is lost per rectum (mucus, blood, tissue exudates) and when this loss is marked it leads to hypoproteinemia and loss of weight, especially when the patient is discouraged, unhappy, anorexic, and taking very little food.
2. Blood loss may be marked, with resultant anemia, weakness, etc.
3. Absorption of toxic material from the large bowel can occur, giving rise to various conditions such as toxic arthritis, neuritis, stomatitis, and endocarditis.

Diagnosis

This is usually easy with the occurrence of the above symptoms, especially if they occur in an emotionally unstable individual. Amebic dysentery can be ruled out by stool examination. Bacillary dysentery can be excluded by stool examination and blood agglutination tests. The diagnosis can be confirmed by sigmoidoscopy and barium enema.

Complications

The complications commonly encountered are:

1. *Hemorrhage* — that may be severe and uncontrollable.
2. *Stricture formation,* leading to intestinal obstruction.
3. *Perforation,* with resultant abscess formation or general peritonitis.
4. *Fistula formation.*
5. *Carcinoma.* Definite figures are not available but it is considered that when these cases are allowed to persist chronically, the incidence of carcinoma is definitely higher in them than in the general population.

Medical Treatment

The main components of a medical regime for this condition are as follows:

1. Rest.
2. Dietary measures — trying to get the patient to take a high protein, high caloric, low residue diet, with vitamin supplements. In this connection, it is considered that natural foods are better than commercial concentrates. Tube feeding may even be necessary.
3. Maintenance of fluid balance.
4. Replacement therapy — blood, plasma, protein hydrolysate, etc., may be given intravenously as required.
5. Antibiotics and chemotherapy. Orally effective antibiotics such as streptomycin, chloromycetin, aureomycin or terramycin, or the intestinal sulfas may be given in an effort to eradicate infective organisms from the intestinal tract. The antibiotics may be used parenterally when toxemia is present or to reach organisms that have penetrated deeply into the intestinal wall.
6. Symptomatic therapy is given as required — sedation, analgesics, antispasmodics, obstipants, iron, etc.
7. Psychotherapy also is a part of medical therapy. It may seem ridiculous to stand there telling this miserable creature living on a bedpan that she must eliminate her problems and learn to live with those that cannot be eliminated, but apparently sometimes it helps. Certainly, patience, kindliness, and understanding in dealing with the patient are essential. These are not things for administration by specialists — these are just part of the common sense and decency with which I am sure all those who read this are endowed.
8. ACTH and Cortisone. Lately these drugs have been tried in this condition and they seem to have given some very encouraging results. It is considered that they reduce the inflammatory reaction and improve the circulation and exchange of tissue fluids. More time is required to evaluate these drugs properly in the treatment of this condition.

In a general way, it is considered that if a cure is to be effected by medical measures, it must be done while the disease is confined to the mucous membrane of the bowel. When the disease has penetrated more deeply into the bowel wall, so that permanent deformation of the bowel has resulted, a medical cure is probably impossible.

Surgical Treatment

Surgery is indicated when medical treatment has failed or when complications have developed. It may be necessary as a lifesaving measure in certain acute fulminating cases. Present-day surgical treatment of this condition consists of the establishment of an ileostomy and removal of the colon and usually also the rectum (done in two or three stages). Surgery appears to be required in about one-third of the cases.

It used to be that patients were seldom referred for surgery till they were moribund or very near it — this because ileostomy was regarded as a terrible affliction, difficult to manage and beset by later complications. Happily, that state of affairs has changed so that now an ileostomy, while perhaps not entirely a pleasant thing, is far, far more tolerable than chronic ulcerative colitis. This is due to improvements in the technique of the surgery and also to improved ileostomy bags which can be accurately fitted and cemented to the skin to prevent leakage.

From the above it is apparent that medicine offers enhanced possibilities of relief from this disease if the diagnosis is made reasonably early. When all else fails, surgery offers a hope of cure of the disease and restoration of the patient to a useful life.

Home Nursing and Civil Defence

Catherine MacDonald

Communities in all the provinces have joined with the Federal Government in talking and planning for civilian defence. It is time for the women of Canada, especially the wives and mothers, to become aware of their responsibilities and prepare themselves for the part they should play in a national emergency. Women, anxious about the safety and protection of their families, should start now to make themselves ready to handle emergencies and accept greater responsibilities than they have ever had to face before. We are all far too dependent on the modern conveniences, modern facilities, and organizations that we accept as an everyday part of our lives. We forget that if we are caught in the middle of a fighting war many of the things we accept as a matter of course will be wiped out — electricity, gas and water lines broken and disrupted, traffic disorganized, hospitals and medical facilities overburdened to the point where they will only try to handle the most acute and serious cases readily accessible to hospital stations.

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I would like to see every woman in Canada take a course in home nursing as part of her share in preparing for civilian defence and the protection of her family. We know that even now, when we are not involved in a war, there is a great shortage of trained nurses and hospital space. The situation would be much, much worse with a war on our hands. Without any disloyalty to my profession, I believe that any woman with ordinary brains and intelligence can be taught, through a simplified home nursing course, the fundamental essentials of nursing — the simple procedures and practices that enable a woman to give her own family adequate nursing care at home. A widespread working knowledge of home nursing and first aid would save many lives in civilian defence.

During the last war I taught several home nursing classes: first for the Red Cross, later for the St. John Ambulance Association. These excellent courses are fundamentally the same. Each organization provides its own textbook but when I taught my classes I followed my own schedule to some extent for the ten classes. The equipment I used was very simple and strictly confined to equipment normally

found in ordinary homes. The procedures and practices were all that were necessary to give a woman sufficient information to provide good nursing care in the home. The classes were held once a week and lasted for two hours. The first hour was used to review and explain the section in the home nursing textbook covering the lesson; to describe and demonstrate the procedures to be covered that evening. The second hour was taken over by the pupils practising the procedures. I always tried to get each pupil to practise each procedure in the class and then to keep practising it at home, using someone of the family as a patient.

The women who were really interested did practise at home on their children. They became very adept at making beds with a patient in them, giving bed-baths, taking temperatures, and all the other simple procedures taught them. They became good practical nurses capable of giving good nursing care in the home. I feel that these courses provide a valuable training for any woman and they should be considered a very necessary part of our civil defence program.

Any graduate nurse from a good hospital is capable of teaching these home nursing classes without any additional training. Every step should be described in familiar language so that the pupils can understand and follow each procedure and the reason for it. It is a mistake to teach home nursing classes in the demonstration classrooms of a hospital. Then the women feel that they cannot care for sick in their own homes without the elaborate equipment of hospital beds, etc., that they see in the hospital. It is much more practical to use a small hall or, if the class is small, a large bedroom in a private home. The only permanent equipment needed for the whole course of lectures is a blackboard, a bed (preferably an ordinary single bed), a mattress, two pillows, and a bedside table. The other equipment can be brought in to each class as it is needed, depending on the procedure to be taught at that particular class.

When I taught my classes, the permanent equipment mentioned above, extra thermometers for the class to practise with, and rolls of bandages were supplied by the society sponsoring the classes. All of the other equipment I brought in myself from my home as it was needed for each demonstration. The only equipment I ever used that I thought might not always be found was a bedpan and an enema bag. Everything else was available in every home in the community. The patient during the demonstrations was usually one of the pupils, or a small child, because the pupils got the feel of handling a human body. They were much more careful and painstaking than if they were flopping a large doll around in bed.

I found that the demonstrations are the most important part of the home nursing course. True, the handbooks should be followed and studied in conjunction with the classes. They give the theory and are wonderful afterwards to refer to when needed but it takes an actual demonstration to show how simple many of the procedures are. Giving a bed-bath seems like a difficult task to most women but once they have seen one given, and have given it themselves, they are amazed at how simple the whole thing is. Making a bed with a patient in it is often pictured as a tricky job. The students soon find it is accomplished with a simple routine that makes the task easy. Taking temperatures, counting pulse and respirations become routine after they have been demonstrated and practised, and they are no longer thought of as mysterious procedures but simple duties. The women discover that caring for the sick is not necessarily a complicated, difficult operation but can be relatively simple when they acquire the knack and routine used for the fundamental items necessary for a patient's care and comfort.

The following outline of our classes shows the procedures the teaching registered nurse should demonstrate and the simple equipment needed for each:

The FIRST AND INTRODUCTORY class should be devoted to explaining the essentials of nursing. The pupils are

told how to recognize the early symptoms of sickness and when to call a doctor. The common complaints are described in their simplest form: change of color, fever, pain, loss of appetite, and loss of weight, etc. The importance of accurately observing and reporting symptoms to the doctor is stressed. The class is shown how to keep simple charts, or just a record on notepaper, of the patient's temperature, pulse, respirations, symptoms and complaints, also treatments and medicines given. They are told the importance of writing down all the doctor's orders and directions — the medicines and treatments he prescribes, the amount and the time they are to be given. It is very necessary to stress the wisdom of following the doctor's orders and directions exactly, giving the exact medicines and doses prescribed, because so many people are apt to deviate and use remedies suggested by grandmother, patent medicines brought in by a neighbor, or even change the dosage of the medicine ordered. The instructor should describe how to arrange the sick room for the greatest convenience of the patient and nurse, keeping in mind the protection of the rest of the family against contagion. The demonstration should show how to keep a chart or record, how to give and measure medicines.

Equipment needed: Notebook, chart sheets, pencils, small tray with a glass of water, medicine bottle filled with colored fluid, teaspoon, tablespoon, eye-dropper, several assorted pills and capsules.

At the SECOND CLASS how to take a patient's temperature, pulse and respirations, and how to chart them are taught. It takes a considerable time for the women to get accustomed to reading a thermometer, finding a pulse and counting respirations. Have them work in pairs, practising on each other so they may acquire the necessary knack and become proficient. It is always wise to demonstrate both mouth and rectal thermometers, explaining the advantage of each, the difference in their reading, and when it is advisable to use one in preference to the other. Very simple thermometer technique is also essential. The women should be urged to practise daily on the family at home until they become sure of their skill in reading thermometers, taking pulse and counting respirations.

Equipment needed: Charts and pencils; a small tray with a glass containing an antiseptic solution to hold the thermometers; a glass with water to hold the clean thermometers; tissue wipes cut from paper napkins; rectal thermometer in separate glass; a jar of vaseline; watch with a second hand.

The THIRD CLASS centres around making a bed with a patient in it. Along with this demonstration of bed-making it is advisable to show the class how to lift and move a patient in bed without unnecessary strain on the nurse. The use of pillows to make a patient comfortable is shown at this time for improvised back rests, supporting the patient on his side, under the knees, and supporting the feet. The women can also be shown how to make a moisture-proof drawsheet with common table oilcloth, plastic or rubber sheeting, and how to improvise drawsheets from old cotton.

Equipment needed: Extra pillows, moisture-proof drawsheet, four full-size sheets, two drawsheets, four pillow slips, one or two blankets and one spread.

The FOURTH CLASS brings us to the bed-bath. If the pupils are modest about acting as patients for this class a small child may be used. Every step of the procedure — from the proper temperature of the room to having all necessary equipment on hand before the bath is commenced — is explained and demonstrated. It is a simple matter for the women to practise at home. It can be made an entertaining game for the children to have a bed-bath instead of their regular bath in the tub until the mother is sure of her routine and procedure. Care of the mouth and teeth is explained and demonstrated. This is an important chore that is often ignored or forgotten by home nurses. The regular, routine care of the hair is shown in conjunction with the bed-bath and a demonstration may even be given of washing a patient's hair in bed.

Equipment needed: Necessary linen for the bed, wash basin, bath towel, face

towel, two washcloths, soap dish and soap, toothbrush, toothpaste, glass, small bowl, comb and hairbrush, nail file. If demonstrating hair washing: a large basin to catch water, a rubber sheet, two large pitchers to hold soapy water and rinsing water, also extra towels.

The FIFTH CLASS demonstrates simple treatments: Giving an enema; giving a douche; care and use of hot-water bottles; applications of hot and cold compresses; making and applying simple poultices. A small child may be used as a patient for this class without actually giving the enema or douche. It is important for them to know the proper position of the patient for each procedure and how to lift them on and off the bedpan. The proper care and use of a bedpan should be explained at this time. How to fill a hot-water bottle properly can be demonstrated, the importance of having a cover on the hot-bottle stressed, a warning given about the risk of burns, and when and where not to use a hot-water bottle. The women should be shown how to improvise a hot compress wringer from canvas or strong cotton, using two pieces of cut broom handle for the handles. Show how pieces of old blanket may be cut up for hot compresses, folded cheesecloth used for cold compresses. It is sufficient to demonstrate two poultices — linseed and mustard — showing how they are mixed and applied and warning about the danger of burning the patient.

Equipment needed: Bedpan, bedpan cover, toilet paper, vaseline, enema bag, rubber sheet, douche nozzle, pitcher to hold soapy water, hot-water bottle and cover, wringer for compresses, woollen material, basin in which to boil the hot compresses, bowl with cracked ice for cold compresses, folded cheesecloth.

The SIXTH CLASS explains the simple precautions to be followed when caring for a patient with communicable disease. Show how to isolate him from the rest of the family and how it is possible to care for him without spreading the disease to others. Explain and demonstrate details of isolation technique. Describe how to disinfect linen and clothing, how to clean up a sick room after the patient has recovered. Show how to sterilize dishes and equipment that are used every day.

Equipment needed: Cover-all gown tying in back, clothes boiler, bed linen, towels, large paper bags, pile of old newspapers, paper towels, paper napkins, metal tray, dishes and flatware for regular meals, pot large enough to hold all china and silver from tray.

The SEVENTH CLASS discusses the value of different diets for the sick, the importance of following the diets prescribed by the doctor, and demonstrating how to set up a tray for a patient. It is important to explain why the nurse must prevent malnutrition and dehydration and, if the patient is very ill, why she must keep a careful check of the fluid intake and output. A tray should be set up with the necessary china, flatware, etc., to serve a three-course dinner, showing how simple it is to serve a full meal from a tray. The women can be shown how to improvise a simple bed-table or tray-rest for the bed and how to feed a patient too sick to help himself.

Equipment needed: Blackboard, notepaper to record intake and output of patient, tray, dishes, flatware, salt and pepper shakers, sugar bowl, cream jug, teapot, card table or improvised tray-rest, small tray with glass and feeding tube.

The EIGHTH CLASS introduces the essential preparations to look after an obstetrical patient at home. This is an important class because, in an emergency, maternity cases will have to be delivered and cared for in the home. Show how to sterilize the necessary supplies and how to arrange the room in readiness for the delivery. Explain in the simplest way how to cut and tie the cord if, perchance, one of the class is forced by circumstances to deliver a baby. A pair of scissors, a piece of rubber tubing, and some narrow bobbin tape can be used to demonstrate the method of tying the cord. Show how to improvise protective pads for the bed from newspapers and worn sheeting, how to protect the furnishings with newspapers during the delivery.

Equipment may be as elaborate as the teacher thinks necessary and space and circumstances permit or it may be

cut down to such bare essentials as: Scissors, bobbin tape and pot in which to sterilize them; improvised protective pads; a sheet and towel folded and wrapped ready for sterilizing. The home nursing textbooks give lists of the equipment needed for a delivery, show pictures of rooms ready for a delivery, and patients in position. From these the class can get a very good idea of what is needed.

The NINTH CLASS demonstrates giving a newborn a bath, the care of the navel, preparing a formula, how to care for bottles, etc. A baby, even if it is several months old, should be used to show the proper technique and care. One formula can be made up in front of the class. The importance of bottles and all equipment being kept sterile should be stressed.

Equipment needed: Wash basin, two large soft bath towels, two soft washcloths, soap dish and white castile soap, tube of vaseline, jar of olive oil or baby oil, absorbent cotton, set of fresh clothes for the baby, pot, two baby bottles, two nipples, two covers for bottles, teaspoon, can of evaporated milk, can of corn syrup, kettle of boiled water.

In the TENTH CLASS bandaging is taught using two- and three-inch bandages. Applying bandages to hands, feet, knees, elbows, etc., is demonstrated and practised by the class. Again it is advisable for the women to work in pairs, each pupil practising every procedure, then taking her turn as patient while her partner bandages her. The women can be reminded to practise their bandaging at home on the family until they become proficient.

Equipment needed: Enough two- and three-inch bandages to provide each pupil with two rolls.

It can be readily seen from the above outline that if the home nursing pupils have attended the full course of ten classes, and if they have absorbed, assimilated, and become proficient in the nursing procedures demonstrated at the classes, they should have acquired sufficient foundation to care for sick in their own homes. It is for the protection of our homes, the lives of our children and other civilians, that I urge women all over Canada to attend home nursing classes. I would also urge registered nurses to consider the time spent teaching these classes as a very worthy contribution to preparing our country for civilian defence.

I Was a Nurse

KATE WATSON

(Continued from the JULY issue)

Part IV

IN 1924, I DECIDED to invest all my savings in a trip abroad. New York, Naples, Capri, Rome, Nice, Madrid and many other cities passed in fascinating panorama. It was springtime when we arrived in Italy and, as we travelled north, each country in succession was in gorgeous bloom. Even when we arrived in England at the end of June the pink hawthorns were still laden with blossoms. I pressed a tiny sprig from a huge hawthorn tree at Kenilworth Castle. At the end of three months we arrived home with empty pocketbooks but with life enriched by unforgettable memories, which have since constantly added to the zest of living.

In 1929 the depression came and, as in most professions, it hit nursing a very hard blow. There just wasn't money in circulation to afford a nurse. Patients were grateful if they could pay their hospital bills. It was quite common for nurses to wait their turn for a case for five- or six-week periods. It would not have seemed so trying had it been a condition which anyone could have previously anticipated or for which they could have prepared them-

selves. But, like those in other professions, we came through the depression with our chins up. Very many of us live on the outer edge of our inner potentialities, until difficulties arise and prove our character and spiritual calibre.

Apart from the inner satisfaction of nursing as a profession of service to others, the nurse meets many interesting people and makes lasting friendships. One of my most interesting patients was the wife of Canada's Commissioner to the League of Nations. The League was past its infancy at that time and had arrived at the stage where it was beginning to receive some criticism as to its value in the promotion of world peace. My patient told me many incidents not entirely familiar to the general public, which indicated that the League was performing a very real service to humanity; and that it had been instrumental in settling disputes which might have had world repercussions but for their peaceful intervention. I still correspond with the daughter of the Minister of Justice to the last Czar of Russia. She was one of the most charming and highly educated women I have ever been privileged to meet. It was not only her fine cultural background but her deeply courageous spirit which inspired me. Such friendships add much to the rich pattern of life.

Through many years of nursing I formed the habit of always carrying with me some reading material. In some cases there were good opportunities for quiet reading and other patients enjoyed having the nurse read aloud during their convalescence.

It is many years since that May morning when I first went in training for a nurse. From the comfortable security of happily married life I look back reminiscently.

After an extended absence, I returned to my old home town. It was evening when the train slowly pulled into the familiar station. Each side of the main street was packed almost solidly with cars — some old, many of them the latest models. The countryside was having its Saturday evening visit and shopping spree. Next day, we walked past the spacious home of the doctor for whom I had nursed so frequently in bygone days and who had some years ago passed to his rich reward. They told me that a young doctor and his wife (who was a nurse) now owned it and had converted it into an obstetrical hospital where most of the prospective mothers from around the countryside came for their confinements.

Later on, I visited the big city and the hospital which for so many years represented a major part of my life and thinking. Memories kept crowding in — almost uninterruptedly — because the faces, for the most part, were unfamiliar and few beckoned. I could see that there were many obvious changes and those which were not so visible to the casual observer. They told me that great improvements were being planned. I looked into the future and could envision other changes, for each year science was making great strides in its ceaseless quest for knowledge; and nurses were seeking a better way. One could never wish for time to be static or to stay the hand of progress; for progress is good, and this is today. With a strange nostalgia I realized that Time Marches On and that yesteryear is forever gone. And part of my soul cried out for that priceless and intangible something which was lost when the old-fashioned family doctor and his faithful Dobbin moved across the stage, and the curtain was lifted on a new day.

Good mental health implies freedom and autonomy, that good character is evidenced only in free choice and that democracy means free and responsible citizens.

— Prof. John R. Seeley

Every generation enjoys the use of a vast hoard bequeathed to it by antiquity and transmits that hoard, augmented by fresh acquisitions, to future ages.

— Thomas Macaulay

Nursing Service in Health Insurance

THE FOLLOWING BRIEF, dealing with the implementation of the recommendations of major concern to nursing as contained in the provincial Health Survey reports, was presented to the Honorable Paul Martin, Minister of National Health and Welfare, last spring. It is published here for the general information of and study by the nurses of Canada.

Members of the Canadian Nurses Association have read with keen interest the reports of the Provincial Health Survey Committees. It is noted that the recommendations show a similarity of nursing needs in all provinces across Canada. We assume that the Department of National Health and Welfare, in planning the next steps for the improvement of health services, will act upon the recommendations made by the provinces. The Canadian Nurses' Association wishes to assist both the federal and provincial governments in implementing the recommendations in which nursing plays an important part. Those of major concern centre around recruitment, research, education, service.

The Canadian Nurses' Association makes the following recommendations, based on those submitted by the provinces. These appear to have high priority and can best be realized through continued leadership by the Federal Government.

RECRUITMENT

Federal grants have been used effectively in the past to stimulate enrolment in schools of nursing and to prepare graduate nurses for special fields. Technical assistance by the Federal Government in the preparation of pamphlets and films has proven valuable in the recruitment program. There is need for a continuous program of recruitment for both professional and auxiliary nursing personnel. We recommend:

1. That funds be made available for a sustained recruitment program to stimulate enrolment in professional and auxiliary nursing schools and to interest graduate nurses to prepare for special fields.

2. That technical assistance be continued for the preparation of materials for recruitment.

RESEARCH, EXPERIMENTATION, AND DEMONSTRATION

New plans to meet the health needs of the Canadian people are rapidly evolving. Canada has unique problems and these can be attacked in a competent and effective manner by a wide program of research and experimentation. We recommend:

1. Further research in nursing education particularly:
   (a) A determination of nursing needs of society as a basis for constructing effective curricula for preparation of nurses.
   (b) Demonstrations in educational methods for the preparation of nurses such as centralized teaching and extension of experimental programs similar to that developed in the Metropolitan School of Nursing in Windsor, Ontario.

2. Additional studies of nursing activities in hospitals and other health agencies similar to the recent "Head Nurse Activity Analysis" conducted by the Research Division, Department of National Health and Welfare.

3. Further study in the use of the team approach in nursing.

4. Establishment of experimental units to demonstrate special services as, for example, a completely generalized public health nursing service; home care programs, etc.

5. Studies of recording and reporting in hospitals and other health agencies.

NURSING EDUCATION

Federal money has been used effectively to provide bursaries for nursing education and to extend and develop teaching facilities and residence accommodation. Funds have been effective in recruiting and preparing auxil-

iary personnel. We recommend that grants be continued and extended for:

1. The improvement of nursing education through:
   (a) Increasing the number of prepared instructors, librarians, and assisting personnel.
   (b) Extending clinical experience in basic courses in nursing to include psychiatry, tuberculosis, public health, and rural hospitals.
   (c) Improving educational facilities — e.g., classrooms, laboratories, libraries, and auditoriums.
   (d) Organizing and developing institutes and refresher courses for graduate nurses.
2. The extension of residence facilities.
3. The study of established courses for nursing assistants and the extension of approved courses with proper certification.

Service

The improvement of nursing care is a major objective in all health plans. To accomplish this, we recommend:

1. The development of organized home care services by such methods as the extension of hospital facilities into the community, by wider use of visiting nursing and housekeeping services.
2. The establishment of licensed nursing and boarding homes under the supervision of an official agency and directed by qualified personnel.
3. The more effective and economical use of personnel.
4. The stabilization of nursing staffs by improved personnel policies, including provision for pension plans and group insurance.
5. The encouragement of better integration of preventive and treatment services among all agencies providing health and welfare services.

Conclusion

The Canadian Nurses' Association, in presenting these recommendations to you, believes that their consideration is essential for the improvement of the health of the people of Canada. We wish to assure you of our desire to cooperate in their implementation. In the past, nursing consultants, employed by the Department of National Health and Welfare, have contributed to the development of nursing in special fields such as industrial hygiene, maternal and child health, civil defence. In the implementation of these recommendations and those of the Health Survey Reports, we recommend that additional nursing consultants be appointed to the Department of National Health and Welfare.

Canadian Nurses' Association

Helen G. McArthur
President.

Esther Robertson
Chairman, Committee on Health Insurance, C.N.A.

M. Pearl Stiver
General Secretary-Treasurer.

Professor Sir James Learmonth, the Edinburgh surgeon who operated on King George VI in 1949, referred to his "ever-increasing debt" to the nursing profession, when he gave the Lister Oration at the Royal College of Surgeons in London.

"Nursing is at once an art and a science," said Sir James. "The existence of a highly trained and devoted body of women is inseparable from, and indispensable to, the practice of modern surgery.

"In both ward and operating theatre, it is never easy to draw a dividing line between surgical care and nursing care, nor is it desirable to attempt to do so, for they are one.

"Moreover, a belief that I have now held for more than 30 years has a factual, although perhaps not a strictly scientific, basis: that when, on occasions, formal treatments and remedies fail, *it is possible for a patient to be nursed back to life and health.*"

Psychiatry and education have much in common. Both have the primary aim of helping the individual adjust to life. In a physician-patient relationship, there is much teaching and learning. In the teacher-student relationship, there is much need for skill in harnessing emotional drives.

— Dr. W. C. Menninger

Psychology for Student Nurses

R. CATHERINE AIKIN, M.Sc.

(Continued from the JULY issue)

LEARNING EXPERIENCES

TO ACHIEVE the objectives that have been decided upon, a plan of learning experiences is next presented. It is thought that these learning experiences will be of interest to the students and are within the range of possibility. All these experiences would help to achieve more than one objective. It is hoped that as this course is actually offered to students they themselves will cooperate in determining the experiences most likely to enable them to achieve their objectives. For the purpose of this article, the writer has drawn up the following outline.

Miss Aikin is the associate director of nursing education at the General Hospital, Calgary, Alta.

Unit I

INTRODUCTION: THE NATURE AND METHODS OF PSYCHOLOGY

Number of class hours — 3.

Content	*Learning Experiences*
Similarities and differences in the fields of psychology, psychiatry, and psychoanalysis	Lectures
How, where, and when each is used	Discussions
The scientific method	Selected readings
Methods of studying human behavior	Simple experiments:
Psychology as a scientific study	Word-association test
Branches and fields of psychology	Ink-blot test
Casual observation versus scientific facts	"Rumor" test
How the study of psychology may help the nurse	
Some cooperative planning of the learning experiences of the course	

Unit II

A HUMAN BEING'S EQUIPMENT FOR LIVING AND THE FORCES WHICH INFLUENCE THAT EQUIPMENT

Number of class hours — 4.

Content	*Learning Experiences*
The nature of heredity	Lectures
The carriers of heredity	Discussions
Inherited characteristics	Selected readings
Prenatal growth and development	Film on heredity
Congenital versus hereditary factors	
The child at birth	
The nature of environment	
Social norms and values	
Social behavior	
Social change	
Crowd behavior	
The interaction of heredity and environment	

Unit III

MOTIVATION, LEARNING, AND THINKING

Number of class hours — 6.

Content	*Learning Experiences*
The meaning of motivation	Lectures
Biological determinants of motivated behavior — instincts, physical drives, etc.	Discussions
Non-biological determinants of motivated behavior — social motives, etc.	Selected readings
The development of a conscience	Simple learning experiment with number-symbol substitution
Common human needs	Students each to find a theory of learning in the literature and present it to the class either singly or in a group
How we learn	
What we learn	
Learning as a function of the learner	
Learning as a function of the material to be learned	
Retroactive inhibition	
Transfer of learning	
Retention	
Thought	Student to make a survey of own study habits and those of classmates, noting both desirable and undesirable habits. Discussion of these from point of view of effective learning. Student to outline a study plan and keep a record of day-to-day studying to see if adhering to plan and what changes need to be made.
Sensation and perception	
Attention	
Reasoning	
Problem-solving	
Application of learning principles to nursing	
Effective use of study time	
Physical conditions for effective study	
Effective planning of study	
Selection of sources	
Effective use of various sources	
Determining relevancy of data	
Recording and organizing data	
Presentation of the results of study	
Evaluating study	Individual conferences

Unit IV

EMOTION, CONFLICT, AND MECHANISMS OF ADJUSTMENT

Number of class hours — 6.

Content	*Learning Experiences*
Emotion	Lectures
The facilitating and inhibiting effects of emotion	Discussions
The components of emotion — internal, external, and feeling	Selected readings
Common emotional responses	Students to search literature for descriptions of mechanisms of adjustments and suggest an example of each mechanism as indicated in own or others' behavior
The learning of emotional responses	
The modifying of emotional responses	
How a nurse can guide emotional responses	
Causes of stress and strain	
Nature of conflicts and frustrations	
Mechanisms of adjustment	Discussion of these mechanisms
Emotional maturity	Students to prepare a paper on emotional maturity

Unit V

THE PERSON AS AN INDIVIDUAL

Number of class hours — 8.

Content	*Learning Experiences*
The concept of personality	A group of students having clin-

Biological determinants of personality	ical experience on the same ward are to select a patient whom they wish to observe in relation to some of the aspects that they learned about in this course and which they have helped list. Each student is to make her own observations. These are to be compared with those of other students in the group. A group paper is to be prepared explaining agreements and disagreements and the validity of their observations. This explanation is to be supported by facts and principles found in the literature whenever possible.
Environmental influences contributing to personality	
The analysis of personality	
Attitudes	
Capacities, including intelligence	
Individual differences due to sex, age, race, nationality, class, and creed	
	Lectures
	Discussions
	Selected readings

Unit VI

MENTAL HEALTH

Number of class hours — 3.

Content	*Learning Experiences*
What is health	Lectures
What is mental health	Discussions
How a nurse might strive towards mental health	Selected readings
How a nurse might assist others towards mental health	Film on mental health

As part of Unit IV, one of the suggested learning experiences is that students search the literature for descriptions of various mechanisms which individuals use to adjust to conflicts and frustrations. Some of the possible sources of information would be given to the student, together with some suggestions of the type of literature containing the desired information. It would be expected that the student would locate descriptions of such mechanisms as rationalization, projection, compulsion, identification, flights into fantasy, sublimation, and the like. Having obtained this information, the student would look for examples of these mechanisms in her own behavior and that of her classmates, friends, family, and others. After the students have had the opportunity to study adjustments in this way, a class period would be used for a discussion of the frequency of occurrence, the normalcy or abnormalcy, and the usefulness of such ways of adjusting.

It is thought that this learning experience would help to achieve all of the objectives. Consideration of the experimental research would aid in achieving objective 1. Consideration of how these mechanisms are acquired would aid in achieving objective 2. The student would be guided in her search through the literature, thus helping to achieve objectives 3 and 4. Noting differences in the ways individuals adjust and discussing the health aspects of such adjustments would aid in achieving the other objectives.

Another suggested learning experience in this unit is concerned with emotional maturity. It was stated earlier that since they are approximately 20 years of age, one cannot expect these students to be emotionally mature. They can, however, understand

what is meant by emotional maturity and gain some conception of the goal toward which they may strive.

In drawing up a description of what she considers an emotionally mature person to be, the student will seek help from several sources. A descriptive outline might be prepared, combining the considerations of the students and the teacher. The students might then be asked to prepare a paper discussing this outline in relation to individuals whom they consider mature emotionally and stating their own reactions to each aspect.

Here again, it is thought that all objectives are involved. The student will become more familiar with dependable sources of data and have an opportunity to practise new techniques of study. A discussion of the opinions versus scientific facts will aid in achieving objective 1. Individual differences — emotional, intellectual, and physiological processes — would all be considered and the experience should help the student to understand the content of the other objectives.

Organization of Learning Experiences

In the introduction, it was stated that this course in psychology is an introductory course and is followed in the succeeding years by courses in child and abnormal psychology. Many of the major elements of this course will be repeated and extended in the later courses, thus providing for continuity and sequence. A conscious effort must be made to integrate this course in psychology with the other courses in nursing and the allied arts. Continuity and sequence as well as integration of the experiences help to produce a more permanent and cumulative effect upon the student. A list of suggested elements common to the courses in psychology and nursing and the allied arts would include such items as:

Concepts

A. *Regarding individual "human nature":*

1. There are basic human needs which individuals seek to satisfy. All human beings have certain common needs but there is variety in their manifestation and attainment.

2. The underlying motivation of a person has effects both on him and on others.

3. Much of our talk and action arises from unconscious motivation.

4. Frustrations in human life have serious consequences. Fears, compulsions, defences, inadequacies, compensations, and prejudices limit individuals' and social effectiveness.

5. Although some individual characteristics are largely the result of inborn factors, many of the most important traits are acquired; much of the "self" and individual personality are formed by experience and training.

6. Human beings are almost infinitely teachable. In a sense "human nature" is being changed every day.

7. Ideals can be dynamic in human progress, especially when they are continuously clarified, reinterpreted, and reapplied in changing situations.

B. *Regarding man and his physical environment:*

1. Space is an important dimension in human affairs, for location affects resources, ease of transportation and communication, and many physical conditions of living.

2. Time is an important dimension in human affairs, for events have roots and consequences and developments (changes) which require time.

3. Climate, land features, and natural resources have profound effects on man. Development, use, and conservation of resources strongly influence his life and future.

4. Man can influence his environment.

C. *Regarding man and his social environment:*

1. Man forms social institutions and organizations to satisfy his needs.

2. People are interdependent.

3. Social groups develop patterns for group living, thus producing customs, cultures, civilization, and society.

4. Increasing knowledge and invention produce ideas and technology that disrupt some previous social arrangement. There is social lag in making adjustments to these disrupting forces.

5. An effective social group must provide both for individual needs to be

satisfied and for integrated productive group activity.

6. Social groups can be reshaped to fulfil their functions more adequately.

VALUES

A. *Attitudes toward self:*

1. Growing from self-love to self-respect; accepting of self, realization of one's own worth.
2. Integrity, honesty and frankness with self; objectively critical of self.
3. Hopefulness for the future.
4. Willingness for adventure; sense of mission, of reformation, of great crusade.
5. Desire to make a productive contribution, not to be a parasite.

B. *Attitudes toward others:*

1. Respect for the dignity and worth of every human being, regardless of his racial, national, economic or social status.
2. Cherishing variety in people, opinions, acts.
3. Equality of opportunity for all.
4. Tolerance, goodwill, kindliness.
5. Desire for justice for all.

C. *Attitudes toward social groups to which he belongs:*

1. Loyalty to world society and world order.
2. Acceptance of social responsibility.
3. Willingness to submit one's problems to group study and group judgment.
4. Balance of integrity in individual and group participation.
5. Loyalty to the social purpose of the group rather than indiscriminate loyalty to whatever the group does.
6. Willingness to work for an abundance of the good things of life for all peoples.

D. *Intellectual and esthetic values:*

1. Love of truth, however disconcerting it may be.
2. Respect for work well done, worthy of socially directed effort as well as achievement.
3. Freedom of thought, expression, and worship.
4. Love of beauty in art, in surroundings, in the lives of people.
5. Respect for reasonable procedures rather than force as the only proper and workable way of getting along together.

SKILL, ABILITIES, AND HABITS

1. In analyzing problems.
2. In collecting facts and data.
3. In organizing and interpreting data.
4. In presenting the results of study.
5. Ability to do independent thinking.
6. Ability to analyze argument and propaganda.
7. Ability to participate effectively in group work.
8. Good work habits — planning of time, efficient use of time.
9. Ability to interpret a social situation, to recognize motives and needs of others.
10. Ability to foresee consequences of proposed actions.

This course in psychology is a specific subject course which is divided into six units. The learning experiences are organized around the principle of building a whole from the parts. Following the introductory unit, the learning experiences are in relation to the various aspects of motivation, learning, thinking, emotion, conflict, adjustment, and individual differences, building up to a discussion of personality and mental health. The pattern is from specific aspects to a generalized whole. This organization, in itself, aids the student to understand the relationships of mental, emotional, and physiological processes.

EVALUATION

To evaluate the extent to which the educational objectives of this course are actually being realized by the proposed program of curriculum and instruction, several procedures are suggested. The students might be given a "pencil and paper" test of multiple choice objective items, carefully prepared to measure knowledge and understanding of the various areas of content indicated in the objectives. These items would be numerically scored and would indicate whether the students have understanding and/or knowledge.

Four of the suggested learning experiences require that the student search various sources for information. The results of this search would be submitted and evaluated by the teacher on the basis of the number of sources

used, the kind and amount of material found in any one source.

To evaluate the extent to which students have acquired techniques by which individual problems of study may be attacked, the study plans and the day-to-day record of study activities would be discussed and appraised by each pupil and the teacher. Time sometimes is an obstacle in having individual conferences with each student but the writer believes that this could be done in most schools of nursing if carefully planned in advance. A check list might be drawn up and used by the student to evaluate her own progress and both a numerical and descriptive summary might be recorded by the teacher.

By these procedures, the extent to which the three desired behavioral changes have occurred might be evaluated. Each of the content areas would need to be weighed and would be evaluated by these same instruments.

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Cues for Building up a Stable Staff

High ideals, straight thinking, and a skillful performance are three fundamentals to success in any honorable field of work. It takes a combination of all three to bring success no matter what the undertaking. The successful nurse administrator is one who can draw from people the muscle power, brain power, and feeling power to fulfil the purposes of the agency. Skill in handling human relations is essential wherever one person becomes responsible for another's work. Such skill is the art in administrative science.

All human beings are motivated by similar factors pertaining to their work, such as: (1) financial incentives, including cash wages, benefit programs, security; and (2) job satisfaction through opportunity to use one's abilities, opportunity to grow on the job, take on more responsibility, to show capacity to advance on the job, and desirable work situation.

Financial incentive is never enough. The other factors loom as important, if not more so, in job satisfaction. With these motivations in mind, cues for maintaining relationships which will build a stable staff are logical. They may well form a pattern of behavior for nursing administrative and supervisory personnel:

1. Treat people as individuals. If no more, a cheerful good morning, a smile or nod of recognition of the person means a lot.
2. Establish common understanding. It is the other person who must understand you, if you wish a starting point for pulling all hands together to work for good service.
3. Let co-workers know what management is trying to do.
4. Let co-workers know how they measure up.
5. Respect the feelings of other people. Feelings are facts to people. If need be, feelings must be changed to secure wholehearted response.
6. Remember the method and the manner are often more important than the words you say.

—*Hospital Nursing "Newsletter"*—National League for Nursing, Feb. 1953.

Nurse-Teacher Cooperation

RITA DOYON, B.Sc.

MODERN POLICIES and practices in an up-to-date school health service recognize the need for cooperative and coordinated effort on the part of doctors, nurses, and teachers. The teacher's observations are of great importance because they reveal conditions that could not be detected by any other means. She is the one who can tell if a pupil loses interest in his work, is listless, shows evidence of approaching communicable disease, or constantly asks to have questions repeated. She knows the pupil who is absent frequently because of sickness, the one who is worried, the one who is losing weight. Such pupils need help. They should be referred to the nurse for examination. Only as a teacher accepts responsibility for observing her pupils and referring to the nurse those who do not appear to be, or are not, well will the school health program be of value to child health. A program cannot be effective without the teacher's wholehearted and intelligent help.

The position of the teacher in the school health program is determined by the interest of her principal. It is absolutely essential for us, as nurses, to sell the idea that the teacher is the most important single factor in an up-to-date successful school health service. As soon as we convince the principal of this, then the time will be found for each teacher to devote the necessary attention to her responsibilities in this regard.

The "teacher-nurse conference" is the most important function in school health work today. The success of the whole program depends upon the nurse and the teacher working together, each one doing her part to render the best possible service to the individual child.

Miss Doyon is on the staff of the Montreal Department of Health.

Everyone concerned with the health and happiness of children in the school must cooperate as a *team* if we are to achieve the best possible results. The people who make up this team are: the principal, the teachers, the school nurse, the school doctor.

No matter how many traits or characteristics children as a group appear to have in common, it must never be forgotten that each child is an individual with his many ideas and feelings. When a child first starts school, he brings with him a large part of his family — especially those events that have made deep impressions upon him — as well as the experiences he has had in his personal life. It is well to remember that many of the child's behavior tendencies which appear in school have been produced or influenced by his home. Many of the problems that occur in the classroom have had their origin in the home.

The nurse, the doctor, and the teacher should develop a philosophy that includes interest and skill in the use of diversified avenues to better understand the child's attitudes toward his school work, his home, and his comrades in terms of the behavior symptoms he shows. We, as nurses, must be ready to help the teacher see and understand these important symptoms which the child manifests.

MARY AND PETER

Miss Smith, teaching Grade II, came to the Health Room one afternoon to confer with the school nurse as she was finding seven-year-old Mary a great problem. This child would not obey and seemed to take a perverse pleasure in exasperating everyone. Miss Smith felt she could not stand it any longer.

Miss White, a teacher of Grade IV, came into the Health Room at this moment and complained of a similar pro-

blem concerning Peter. Although she had tried in many ways to win his cooperation, she had not been successful.

After discussing the problems presented by these children, it was decided that the school nurse would visit the two homes and try to locate the source of the trouble. Unfortunately, it was not hard to find! The visits showed convincingly that there was very little hope of obtaining cooperation from the parents. In both homes, the parents seemed to scream at and scold their children constantly. None could find a good word to say for their children. It was literally impossible to reason with them.

The nurse returned to the school with her mind made up that if something constructive was to be done to help Mary and Peter it would have to be initiated by the school personnel rather than the home. The two teachers and the school nurse met at once and discussed the whole situation at some length. The following decisions were made:

The children would not be scolded under any circumstances during the next three weeks. The teachers would ignore, as completely as possible, their irritating, attention-getting mannerisms. At the end of three weeks the trio of planners would meet again and discuss the results obtained by the new method of dealing with these troublemakers.

Three weeks passed. When they met again both teachers exclaimed at once: "It is incredible but our plan has worked!" Both children appeared to have become docile and were applying themselves to their work. They were doing their best to please their teacher and both appeared to be happy. A warm and sympathetic understanding with their teacher was beginning to develop. Perhaps for the first time, these youngsters were conscious of an environment where they would be allowed to grow and express themselves without constant scolding. They were experiencing a new joy because at last they understood that they, too, had something to contribute. They no longer needed to be disobedient to draw attention.

Finding physical defects and endeavoring to secure their correction is important but it is only part of the service that the teacher has a right to expect of the nurse. What should both the teacher and the nurse *know* about the child? Are there special rules to guide them in observing children in order to gain this knowledge?

There is no single answer as to how much, or what, the teacher and the nurse should know about any child. There are no set rules that will unlock the door to an appreciative understanding of human beings. Children are individuals and what is terribly important in the life of one may not be of much significance to another. Experience has shown, however, that most of the things that are vital in the lives of children fall into certain groups: their health and physical condition; the home and family; the school; the teacher. Let us consider each of these in turn.

Physical Condition

A child who is not well, or who has serious physical defects, cannot behave like a "normal" child, nor can he do justice to himself. Therefore, the first information needed concerns his health and physical condition. His *eyes* — how well does he see? Does he need a front seat, even with his glasses? His *ears* — are his mistakes in spelling traceable to the fact that he simply cannot hear well enough? His *nutritional status* — is he underweight because his teeth trouble him too much to make chewing a comfortable business? Is he overweight because his mother has never interested him in the less fattening but filling vegetables? These and many other related facts are important bits of knowledge

Home and Family

What is the home like? How many brothers and sisters are there? How does he fit into the family group? Are his companions welcomed when they come trooping in with him? Do his parents believe that "though children may break up the house, they make the home"?

John

John started school when he was six. He was unkempt, seemed very un-

happy, and when spoken to always hung his head. He showed no interest in his work nor his appearance. When asked to do work in class he always said, "I can't do it."

Finally, the teacher came to the nurse asking that John be examined. "Could a physical handicap perhaps be the cause of his apathy?"

A home visit followed. There it was discovered that the mother showed a marked preference for John's sister who was nine years old. Patsy was clever, neat, dependable, capable, and so very likeable. John was dull, extremely untidy and careless about everything. His mother would not even trust him to go to the corner store, just a few yards away, for a quart of milk. There just wasn't anything good about him.

The nurse tried to make Mrs. Jones see that whereas John was only six, Patsy was nine. This period of three years makes a great difference in the level of a child's growth and ability. Boys develop and mature more slowly than girls. Boys are generally more careless with their personal possessions than girls. It was pointed out that in every essential John and Patsy were two different individuals. No two children, even though reared in the same family, are ever exactly alike. Each child has his own characteristics, feelings, aptitudes, and responses. Every child needs to be encouraged to reach the best of his own ability.

It was suggested that Mrs. Jones reconsider the standard of what she expected from John, that she ignore many of his "so-called" shortcomings and that she praise him whenever possible. "Try to make John feel that you are proud of him and that he shares a responsible place in your family."

Mrs. Jones was very receptive. She was shocked to discover that she had not realized that John was feeling so unhappy. Plans were made to have Mrs. Jones come to the school for a parent-teacher-nurse conference. Through careful pre-planning the discussion was both interesting and informative for everyone. The principal joined the group for the latter part of the conference and was very helpful in emphasizing the value of understanding the whole child. Mrs. Jones received help in a sympathetic and understanding manner. She left the school encouraged and determined to try to understand her children more fully. The sequel to this visit that interested the parent-teacher-nurse team was that Mrs. Jones came regularly once a month without being asked, to seek continued help and advice.

John's attitude improved greatly. Unfortunately, due to his earlier emotional handicap, he was unable to make his grade that year. However, the following year showed what his response really could be. He has been successful in his school work and school relationships since. Mrs. Jones, incidentally, has become one of the school's greatest supporters.

The School

How does the child behave in the classroom? Does he appear to like his teacher? Does he get along well with the other pupils in his class? How does he act in the school yard? When compared to the others in his own age group, is he at ease or is he timid, suspicious or fearful, bold, arrogant, antagonistic or impudent?

Ronnie

Six-year-old Ronnie was an excitable, restless and worried child. The teacher noticed that whenever she kept him in at recess or after school to talk to him about his behavior or his school work, he always insisted that the classroom door be left open. When the door was closed he immediately said, "You didn't lock it, did you?" The teacher and Ronnie got along well despite his excitability. There was no antagonism between them.

He was frequently annoying to the other children — pinching, poking or scratching them. Some careful observations were made and it was noted that the other children rarely, if ever, started the trouble. Ronnie always seemed to be the antagonist. When a child fell and hurt himself, Ronnie would shriek in glee.

The teacher turned to the school nurse for help. She wondered what might be behind the behavior that did not seem to be related in any way to a classroom

situation. The doctor, teacher, and nurse had a short conference to discuss Ronnie's curious deportment. It was decided to ask the mother to assist at Ronnie's medical examination.

The child appeared to be well physically but was extremely fearful and nervous. When Ronnie was returned to his classroom the doctor, mother, and nurse had a long interview. The teacher was asked to come in to describe some of Ronnie's antics to the mother. The latter was a very nervous person but was both intelligent and understanding and wanted to be helped. She was thankful that this discussion had arisen because she, herself, had been worried about Ronnie's behavior for quite some time and had not known where to go for help.

The father appeared to be the basic cause of Ronnie's abnormality. This family had once been quite well-to-do. The father had lost most of his money playing the market and the family had been forced to leave their beautiful home. He was now janitor for a private school. Ronnie was not allowed to romp or play at home. His father was extremely critical of everything the little lad did and seemed to relieve much of his emotional tension by scolding him and setting too high standards for him to follow.

The principal was brought into the discussion. The conferees (doctor, principal, mother, nurse, and teacher) concluded that it would be best to have Ronnie examined at the mental hygiene clinic. Arrangements were made and a series of treatments followed. The father and mother also received a great deal of help. Ronnie appeared to improve slightly. Unfortunately, the school year soon ended. Ronnie did not return to that school the following September. It has not been possible to find out where the family moved. We feel reasonably satisfied that something constructive was accomplished for Ronnie and hope that the whole family situation has improved.

The Teacher

The teacher is the pivot of the health work in the school. Recent literature in this field emphasizes that the teacher should be constantly observing her pupils. A pupil who is well at nine o'clock may be vomiting or covered with a rash at eleven. She should observe her pupils from the time they arrive at school until they leave. The nurse and the doctor should act as consultants and be ready to give the teacher advice and assistance when she needs it. The classroom inspection provides an excellent opportunity for the nurse to give the teacher many pointers regarding her observations of the pupils — those children who are straining to hear or see, those with poor posture due to malnutrition or general debility, etc.

Teacher-Nurse Conferences

There should be at least one conference each year when every child will be considered. This should be arranged during the first half of the school year during class hours. The nurse makes an appointment with the teacher three or four days ahead and suggests that the pupils be given seatwork in order that they be kept busy while the nurse-teacher conference is taking place.

On the appointed day, the nurse comes to the classroom with the medical records. The teacher and the nurse sit at a table or desk facing the class and discuss the pupils in low voices. The children should not hear what is being said.

Every pupil — the "normal" as well as the "problem" child — is discussed. Notes are taken by both the teacher and nurse for follow-up purposes.

There should be a most professional attitude in the approach to the work at this time. If both the teacher and the nurse are really interested and fully understand their jobs, the conference method becomes an excellent way of selecting children for:

> The medical examination; follow-up by both the teacher and the nurse; home visits by the nurse.

Armed with the information that the nurse has gleaned from the nurse-teacher conference and the doctor's examination, she is now well equipped to visit the home in the hope of obtaining a better understanding of the

child's background. As a result of these observations, she is more capable of instructing the parents and helping the teacher. The nurse-teacher conference is a two-way method whereby information acquired by the teacher is passed on to the nurse and where different points, known to the nurse, may be given to the teacher. The children who really need help and attention are discussed more thoroughly.

The teachers and nurses learn more about behavior symptoms and problems and their relationship to the child's physical condition, to school work, and to social and economic factors. They learn to work together as a *team* in matters of mutual concern.

Although one major nurse-teacher conference should take place early in the school year, this should not be regarded as the only such contact. Short conferences centred around individual problems must take place as often as necessary concerning individual children whom the teacher wishes to refer to the nurse or doctor. Every one of these children must be given careful consideration. Accurate information should be given to the teacher following the medical examination.

Of what value is the nurse-teacher conference to: the teacher, the nurse, the physician, the parents and, most important of all, the children themselves?

If the nurse-teacher conference is well planned and carried out, the *teacher* will feel that she is a member of a team that is trying to benefit the child. She learns a great deal about normal growth and development, as well as many other important factors concerning health and ways of observing her pupils. For example, at five years of age, a child's eyeball is still growing in size. It does not become fully developed until between the ages of eight and ten years. Therefore, apparent visual defects found in Grades I, II or III may be due simply to immaturity. These children should receive more careful observation for a time if they seem not to see well.

The teacher learns a great deal about the individual pupils and their homes. She also realizes that a healthy child does better school work.

By helping the teacher to observe each individual more closely, the *nurse* herself becomes more skilful and alert in recognizing irregularities. When she realizes that she is part of the team, whether it be working with the teacher, the principal, the parent, the doctor or the individual child, her work becomes infinitely more interesting.

The *physician* has an increased interest because each child brought before him is a challenge to his medical ability. He is more alert because he wants to find the reason why two people (nurse and teacher) have thought it necessary to refer a pupil to him.

Although *parents* do not know what the nurse-teacher conference actually is — or that it even exists — they do quickly sense the cooperation that is taking place at school. When they learn that the child's health is so very important to his school work, they make more serious efforts to help him. A nurse-parent-teacher conference is sometimes advisable to stir interest in a parent and obtain correction of defects. These conferences may serve to familiarize the parent with the whole school health program.

Frequently, the *principal* is drawn into a conference. His general knowledge of the pupils is increased and his cooperation is invaluable in making parents understand.

Children receive more adequate care in a more understanding and sympathetic way. There is less danger of the so-called "normal" child being overlooked.

These contacts between the teacher and the nurse are never-ending. Perhaps some feel that this method of working places more responsibility upon the nurse. Indeed, it does. Moreover, this technique obliges the nurse to accept her full responsibility. It must be admitted that it is actually a much more interesting and more professional way of working. It supplies information for continuous health supervision of the children which is positive, constructive, and protective, as well as being corrective. It helps us, as nurses, to better understand the

normal growth and development of children, as well as seeing their defects.

If the teacher and the nurse collaborate, this procedure identifies problems that need special consideration and that should be referred immediately for treatment. It helps us to plan our work to care for the acute situations in the order of their importance. We want our hours spent at school to be productive and not just routine.

Let us strive to follow these modern methods and instil in the minds of the public that the school nurse's duties have evolved far beyond merely looking for pediculosis.

In the Good Old Days

(*The Canadian Nurse* — AUGUST 1913)

In asking financial support, and even in admitting their patients, do not hospitals tacitly guarantee to do everything possible to effect a cure? If, then, the medico-social clinic and social workers are positively needed to that end, is it not the hospital's plain duty to establish and maintain that department, just as much as it now maintains its drugstore and its ward nurses or its x-ray room?

* * *

Each disease and each individual requires different social as well as medical treatment, and kindly common sense must supplement the doctor's orders.

If we would realize our ideal of treating not only diseases but men, women and children, one of the practical things to do would be to see that the rules and general routine of out-patient clinics are adapted to patients as well as to administrative convenience.

* * *

. . . hospital efficiency must now include the meeting of the problems of after care, remedying home conditions which cause disease, instructing patients in hygiene, and educating the public to cooperation with physicians.

* * *

Nose-blowing drill is one of the new features of the nurse's work during the classroom inspections. If teacher and nurse treat the subject seriously, the children soon accept it as such, and come to realize that a handkerchief is one of the essentials of dress. After the drill is completed the whole class is made to breathe deeply to demonstrate the comfort of clear breathing passages.

Children's Safety

Parents must teach safety to their children and shape the child's behavior and habits to meet this problem in the early years at home. Overprotection is not the answer to accident prevention. Careful instruction combined with intelligent precaution will achieve far greater and more lasting safety. Because most accidents happen to children under five in the home, the following steps are listed in accident prevention:

1. Children should be taught early in life that fires burn them; falls hurt them; poisons make them ill; and knives and scissors cut them.

2. Poisons, disinfectants, and medicine should be kept in locked cabinets or high out of the child's reach.

3. Children should be shown the dangers of bonfires and matches and how to avoid them but at the same time fireplaces should be screened and matches kept out of reach.

4. Handles of kitchen pots should be turned toward the back of the stove and out of the reach of children.

5. Guns, if kept in the house at all, should be put away unloaded under lock and key.

6. Children should be taught how to walk carefully with sharp knives, scissors, and glass containers, as soon as they are able to understand the dangers of such things. Until that time make sure sharp instruments are safely put away.

7. Children should be guarded from perilous climbs and from dangerous ledges and stairs. Screens should be fastened securely with the screening nailed tightly.

— The National Society for Crippled Children and Adults

Nursing Profiles

New honor has come to Canadian nursing with the award of the Florence Nightingale Medal, by the International Committee of the Red Cross, to **Florence H. M. Emory.** Since this Medal was instituted in 1920, as an award for outstanding contributions towards the development and prestige of the nursing profession, it has been presented to six other outstanding Canadian nurses who have rendered conspicuous service in war, disaster or for the public good, as follows:

In 1927 — Miss Margaret C. Macdonald, R.R.C. LL. D., who was matron in chief of the Canadian Army Medical Corps, World War I.

In 1929 — Miss Anne Hartley, R.R.C., who was matron in chief for the hospitals of the Department of Pensions and National Health, World War I.

In 1931 — Miss Vivian A. Tremaine, R.R C., nurse in charge of the Red Cross Seaport Nursery Service, 1922-33.

In 1935 — Miss Jean I. Gunn, O.B.E., LL.D., honorary adviser in nursing, Canadian Red Cross Society, 1928-41.

In 1939 — Miss Jean E. Browne, national director, Junior Red Cross, Canadian Red Cross Society, 1922-49.

In 1949 — Miss E. Kathleen Russell, D.C.L., honorary adviser in nursing, Canadian Red Cross Society, 1942-52.

Miss Emory became the honorary adviser in nursing and chairman of the National Nursing Committee of the Canadian Red Cross Society in 1952. President of the Canadian Nurses' Association during the difficult years of depression, 1930-34, Miss Emory has given unstintingly of her time, leadership ability, and talents to advance the status of nursing and nursing education. Associate director of the School of Nursing, University of Toronto, she is the author of the recently revised "Public Health Nursing in Canada," the only textbook on this topic that has been produced by a Canadian. Miss Emory was chairman of the national committee that sponsored the important Structure Study.

Randolph Macdonald Eaton's

FLORENCE H. EMORY

Rae Chittick has been appointed associate professor and director of the School for Graduate Nurses, McGill University, Montreal. Born in Burgoyne, Ontario, Miss Chittick received her preliminary education in Calgary where her family moved when she was a child. She entered the school of nursing of Johns Hopkins Hospital after teaching public school for two years. Following graduation she worked with the Victorian Order of Nurses in British Columbia then engaged in school nursing under the Saskatchewan Department of Education. Later she joined the staff of the Provincial Normal School in Calgary as instructor in health education. When that school became a part of the University of Alberta, Miss Chittick was given the rank of associate professor of education, directing the health services as well as teaching.

Miss Chittick gained her Bachelor of Science degree in public health nursing from Columbia University and a Master of Arts in education from Stanford University. In

Falliday

RAE CHITTICK

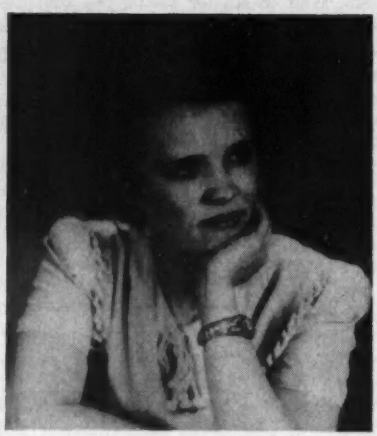
1950 she was awarded a fellowship by the Canadian Education Association. She won the degree of Master of Public Health, cum laude, at Harvard.

President of the Alberta Association of Registered Nurses, 1940-42, and of the Canadian Nurses' Association, 1946-48, Miss Chittick is at present chairman of the C.N.A. Committee on Constitution, By-laws and Legislation.

Christina Cameron Sinclair is director of nurses and principal of the school of nursing of the Royal Inland Hospital, Kamloops, B.C. Born in Vancouver, Miss Sinclair is a graduate of St. Paul's Hospital in that city and holds her Bachelor of Nursing degree from McGill University. After serving as clinical instructor at St. Paul's for a year following graduation, she enrolled in the certificate course in teaching and supervision at the University of British Columbia. She spent the next six years as director of the school of nursing of the General Hospital, Dauphin, Man., then went to the General Hospital, Galt, Ont., as science instructor.

Van Dyck, Montreal

CHRISTINA C. SINCLAIR



HAZEL I. MILLER

Hazel I. Miller has been appointed director of nursing of the Reddy Memorial Hospital, Montreal. A graduate of the Winnipeg General Hospital with her Bachelor of Science degree from Columbia University, Miss Miller engaged in staff and private nursing before joining the Winnipeg Health Department, where she was employed first as staff nurse, then tuberculosis consultant, then district supervisor. In 1947 she was appointed as a National Office supervisor with the Victorian Order of Nurses for Canada in charge of the branches in Western Ontario. During the past year, Miss Miller has served as executive assistant to a commission appointed by the Board of Governors of the Victorian Order to make a complete survey of the Order's activities.

Mary Taylor Shand has returned to active duty as superintendent of nurses of the East Windsor Hospital in Ontario after spending a few months in retirement following an active career with the Metropolitan Health Committee in Vancouver. A graduate of the Vancouver General Hos-

pital, Miss Shand served with the C.A.M.C. during World War I. She held various positions in the hospital field prior to receiving her certificate in public health nursing from the University of British Columbia. Her first acquaintance with Windsor came when she was posted to that branch by the Victorian Order of Nurses. Ten years later she returned to British Columbia — first as superintendent of nurses at the King's Daughters Hospital in Duncan, later going to the Burnaby (B.C.) branch of the V.O.N. She joined the M.H.C. in 1938.

Irene H. Sutherland is now the senior flight nurse of the Saskatchewan Government Air Ambulance Service (*see cover photo*). A graduate of Providence Hospital, Moose Jaw, Sask., Miss Sutherland served with the R.C.A.M.C. during World War II. Upon release from the service, she engaged in general staff nursing in Nelson, B.C., and in private nursing in Regina. She became a flight nurse for the Air Ambulance Service in 1946. Her new duties will include the coordination of the activities of the other flight nurses, the standardization of records, procedures, and equipment maintenance.

After being the beloved director of the school of nursing of St. Paul's Hospital, Vancouver, since 1938, **Sister Columkille**

SISTER COLUMKILLE

has been transferred to the less strenuous life in Notre Dame Hospital, North Battleford, Sask. Associated continuously with St. Paul's since she began her training in 1916, Sister's familiar figure will be greatly missed by the hundreds of nurses who graduated under her gentle tutelage. Not all her energies were devoted to her school. For the past eight years she has been a member of the Executive of the Registered Nurses' Association of British Columbia, serving as president, 1949-51.

Sister Denise Marguerite has succeeded to the directorship of the school.

In Memoriam

Alice (Collins) Crosby, an early graduate of old St. Luke's Hospital, Ottawa, died in May, 1953, in her 76th year.

* * *

Ida Laura Dingwall, who graduated in 1925 from the Swift Current Hospital, Sask., died in North Vancouver on April 23, 1953, following injuries received when she leaped from a burning apartment house. She was 50 years of age. Miss Dingwall had been on the staff of the North Vancouver General Hospital for many years.

* * *

Ella B. Forsyth, who graduated from the General Hospital, Milwaukee, Wis., died in St. Thomas, Ont., on May 6, 1953. Miss Forsyth served as a nursing sister with the C.A.M.C. in World War I.

* * *

Clara C. Langen, who graduated from St. Elizabeth Hospital, Humboldt, Sask., in 1949, died on May 11, 1953, when an aircraft on which she was stewardess crashed in Prince Rupert, B.C. She was 25 years old. Prior to joining the airlines company six months before, Miss Langen had been engaged in tuberculosis nursing in Vancouver.

* * *

Bertha (McIntyre) Phair who was one of the first nurses to graduate from Victoria Public Hospital, Fredericton, N.B.,

with the class of 1896, died on April 2, 1953, at Presque Isle, Maine.

* * *

Mabel Shirkey, who graduated from the Grace Division of the Toronto Western Hospital in 1920, died on April 17, 1953, after a long illness. Miss Shirkey had engaged in private nursing throughout her professional life.

* * *

Isadora L. Smith, a native of Saint John, N.B., who graduated from the Long Island College Hospital, Brooklyn, died in Saint John on April 6, 1953, following a lengthy illness. Miss Smith enlisted with the C.A.M.C. in 1916. She was invalided home in 1919 and had been inactive, professionally, most of the time since then.

* * *

Mary (Livingstone) Stafford, a graduate of McKellar General Hospital, Fort William, died in Geraldton, Ont., on April 24, 1953, following a brief illness.

Psychiatry, Magic and the Holy Man

THE NEED TO "ACCLIMATIZE" Western methods of psychiatry to the culture patterns of their own societies was stressed at a meeting held in Alexandria recently to plan a Mental Health Seminar in the Eastern Mediterranean Region.

Before 1950 there was no psychiatry in the Sudan. Cases of psychoses were taken care of by families, in compounds and in the shrines of holy men. People thought that madmen were possessed of demons, a belief as real as many others they had developed through the generations as a defensive mechanism against their environment.

The situation is gradually changing. Many people are losing their beliefs but so far have not developed a constructive philosophy to replace them.

Dr. Tigani El-Mahi of the Sudan established an out-patient clinic for nervous disorders in 1950 in order to study psychiatric problems and develop methods appropriate to the culture patterns of his homeland. His aim was the establishment of a mental hospital that would apply the techniques most suited to the needs of his people.

It was obvious that the approach had to be modified because there were so many differences from a geographic and climatic point of view. The population of the Sudan, which is a little more than eight millions, is divided into people of negroid stock and pagan traditions in the south and comprising about one-third, and the Arab-speaking Moslems in the north. Dr. Tigani, who works in the north, found that even there he could not apply all the methods that he had learned in his studies abroad.

There are many subjects that are taboo and on which the patient cannot be questioned. Moreover, most of the other questions usually asked of the patient were too intellectual and involved concepts entirely unfamiliar to the average Sudanese. Expressions of mental disorders were different too. Often the gulf between himself and the patient was so great that he could not establish contact. In these cases he sent patients to the religious men, who did good work in treating them.

Dr. Tigani pointed out that the same emotional relationship exists between the religious man and his patient as between the psychiatrist and *his* patient. If the therapist understands the emotional life of the patient, therapy becomes quite easy. The relationship that is established is even more overwhelming in religious therapy.

"I believe that my first and foremost duty to my patient is not to destroy his beliefs," said Dr. Tigani. "They are real to him and have a great influence in his life. Some of my colleagues in other countries think this is a degradation of psychiatry, but magic is very real to the people and we must admit its force."

Dr. Tigani has found that the religious men are also very good with relapses. Fear of relapse is quite often strong in a discharged patient. "In this case I send him to the religious man who gives him an amulet which helps his confidence very much," he added.

He concluded that it was essential that the cultural backgrounds, religion, folklore, and means of biological and psychological adjustment be studied intensively by the growing number of psychiatrists in the Eastern Mediterranean Region.

—*WHO Newsletter,* Mar. 1953.

Trends in Nursing

Annual Meeting Round-Up

IT IS NOT OFTEN that this column is written from the West but such is the case now. Having visited in Manitoba, Saskatchewan and Alberta, and being now in British Columbia, it is much easier to see why we must always bear in mind the similarity of problems in nursing throughout Canada. Our aim must be the improvement of service to the people — our view must be national in scope.

Manitoba

The basis of all nursing service is strong up-to-date legislation. With this in mind, the Manitoba Association of Registered Nurses has been concentrating its energies on the revision of its Act. It having been passed successfully, plans are being formulated whereby it will be printed and distributed to each member of the association. But as well as this, we found that the very busy members were taking an active part in community affairs. Having cooperated so well in the emergency of the flood, the nurses in Manitoba have been called on even more frequently to assist in community, provincial, and federal projects. We are all aware of the survey of nursing resources which took place last fall and which will assist future surveys in relation to Civil Defence. The close cooperation between the M.A.R.N. and the administration of the course in Practical Nursing was most gratifying. We were interested to note that the basic curriculum of the Practical Nursing course had been integrated into the course in Psychiatric Nursing given at three mental hospitals. This is, perhaps, one way in which we can increase the awareness in institutions of the need for a greater appreciation of the psychiatric aspects of nursing.

Saskatchewan

If time would allow, there is no better way to meet our C.N.A. members than to visit in their communities. Next best is to attend an annual meeting.

We were privileged to be at the 36th annual meeting of the Saskatchewan Registered Nurses' Association in Regina. Difficulties in reservations at the hotel allowed only two days but they were days packed with enthusiastic attention. In order to increase province-wide participation, the S.R.N.A. called upon different chapters to present material of general interest. In this way, one chapter was responsible for a project on the Structure Study Report, another on how community services can work together, a group of chapters entertained at a coffee party, and so on. Wherever a chapter had a definite responsibility, the turnout of its members was much increased.

Naturally, in planning our trip to Saskatchewan, there was one project which we were determined to see in action. It was the Centralized Lecture Program which has branches in Saskatoon and Regina. Wishing to see the University of Saskatchewan School of Nursing at the same time, we visited the Saskatoon branch, which is under the direction of Miss Gertrude James. As the first class was just finishing and going back to their home schools for a concentrated period of nursing arts, the staff was unable to give any estimate of its success. However, by the response of the students and the enthusiasm of the instructors, it seems rather unlikely that the project will not prove itself.

While in Saskatoon it was possible to view the new University Hospital which is under construction. The time spent on planning is well illustrated by the many new features which are being incorporated. Very impressive was the thought being put into the planning of food service throughout the hospital. After the many experiments in the centralization of the serving of trays, those in charge are hoping to put the responsibility back on the wards under the eyes of the nursing staff. When the

new hospital opens, the School of Nursing of the University of Saskatchewan plans to include a basic course in nursing. Miss Hazel Keeler, the director of the school, hopes it will be possible to prepare nurses to provide for the needs of all nursing services in large and small communities.

The report of the S.R.N.A. annual meeting will be given at a later date. One set of resolutions, though, is of particular interest now: Finding that the cost of administration of the association's affairs is exceeding its income, Saskatchewan nurses voted to increase their fee to $15 yearly.

Alberta

The large attendance of the members of the Alberta Association of Registered Nurses at its annual meeting once again showed their enthusiastic participation in nursing affairs. Following the pattern of the previous two years, the meeting was held in Banff. In this glorious setting it was gratifying to see the conscientious attendance at the sessions and hear the informed and spirited discussions. Like Saskatchewan, finances occupied a considerable part of the time. After careful weighing the pros and cons, the membership decided that it was necessary to increase the professional registration fee to $15, which amount would include the subscription to *The Canadian Nurse*.

District and chapter participation appears to be increasing in all provinces every year. In Alberta, the Banff Chapter, which is made up largely of associate members, has for three years carried a considerable amount of the responsibility for arranging the annual meeting. They are prepared to give the C.N.A. every assistance at the Biennial in 1954. As well as these association activities, they staff the Well-Baby Clinic in Banff and are ardent community workers. This chapter is but one of the many giving service to their profession at every opportunity.

Alberta bid farewell to Miss Rae Chittick, the newly appointed director of the McGill School for Graduate Nurses. She has been active in the A.A.R.N. for many years and her keen mind will be greatly missed. As chairman of the provincial Educational Policy Committee during the past two years, she has contributed much of her knowledge of general and nursing education to progress in their schools of nursing.

On a visit to the Provincial Mental Hospital at Ponoka, where Miss Edith Kemp is director of nursing, we were delighted to find the staff in the midst of preparing for a two-week course for instructors. Carrying through on our plea to integrate psychiatric principles into the basic course in nursing, arrangements were being made to receive instructors from the schools of nursing and, by means of lectures, films, discussions and demonstrations, illustrate what the "mental" part of nursing is. As someone remarked, when you tell a student to "reassure" the patient, just what do you do? This course is not attempting to teach psychiatric nursing but to show how the principles may be used in all types of nursing. Congratulations, Ponoka and Alberta!

British Columbia

Office rents going up? Every province must be facing this problem. The Registered Nurses' Association of British Columbia has found what they hope will be the solution and it is very simple. Just build your own office! At their annual meeting the necessary action was taken to allow the association to purchase property and build outside of the congested downtown area. With their usual foresight they plan to have enough space to rent part of it for a few years to cover some of the cost and then, as the association expands, gradually to take over more of the unit for themselves. Although the Manitoba Association of Registered Nurses does own their own building, we understand that the R.N.A.B.C. will be the first to build to its own specifications.

While in Vancouver, it was possible to visit the School of Nursing of the University of British Columbia. During the planning of the unit, the director of the school — Miss Evelyn Mallory — was able to take an active part. We found adequate office and

classroom space and excellent equipment, combining to give one of the most attractive, yet functional, arrangements we have seen.

Appreciation of her years of hard work in the interests of the association and a bon voyage for her trip to the I.C.N. in Brazil was demonstrated to Miss Alice Wright, executive secretary of the R.N.A.B.C., by the presentation of a watch. But it was the ovation and standing applause which really showed the esteem in which she is held by the association. Emotions were really disturbed when the entire Council stood to sing "For she's a jolly good fellow." At the same time, Miss Helen Randal, first R.N.A.B.C. registrar, was lauded for her pioneer work in setting the association firmly on its feet many years ago. Her endorsation of the building plans was considered the seal of approval necessary for the successful consummation of this latest venture.

Across the West

One theme we found in common during the last five weeks: No nurse must lose sight of her professional standards and she must see their implications. Each annual meeting reiterated this and its participants rededicated themselves. It was present in the presidents' addresses and in the reports of the executive secretaries. Nursing duties are becoming diffused but the professional nurse must be the guide. Here is a small part of the address given by Miss Esther Paulson, retiring president in British Columbia:

> The rank and file members are not always aware of the personal part each nurse must play in our growth and development in interpreting changes to the general public; and that she influences the degree of respect and confidence which the public accords to the profession. The official organization of any profession can study conditions, analyze the effectiveness of prevailing standards, and recommend changes to meet the needs of our times, but it is the understanding and application of these standards by nurses in their everyday jobs and contact with the public that determines whether or not real progress is being made by the profession in serving mankind.

Orientation et Tendances en Nursing

Les Assemblées Annuelles

Cette chronique vous parvient, contrairement à l'ordinaire, de l'ouest canadien. Ayant visité le Manitoba, la Saskatchewan, l'Alberta, et la Colombie-Britannique, il m'est bien plus facile de concevoir la similitude des problèmes du nursing à travers tout le Canada. Nous devons viser à améliorer notre service aux malades et nous devons avoir un point de vue national.

Manitoba

Les services du nursing reposent sur une législation moderne et forte. Ayant cela à l'esprit, l'Association des Infirmières Enregistrées du Manitoba a concentré ses efforts dans la revision de sa loi. Si elle est adoptée par la Législature, les plans sont déjà fait pour que la nouvelle loi soit imprimée et distribuée aux membres de l'association. En plus, les infirmières prennent une part active dans les affaires de la communauté. Depuis la grande coopération accordée par les infirmières lors de l'inondation, l'on fait appel à leurs services de plus en plus pour aider à la réalisation de projets municipal, provincial et fédéral. Nous sommes toutes au courant du relevé fait au Manitoba, l'automne dernier, concernant les ressources du personnel en nursing, au point de vue Défense Civile. La coopération étroite entre l'A.I.E. du Manitoba et l'administration du cours "Practical Nursing" est excellente. Il a été intéressant d'apprendre que le cours de "Practical Nursing" fait partie du programme d'entrainement dans trois hôpitaux psychiatriques. Voilà peut-être un moyen de faire apprécier le champ si riche offert par l'hôpital psychiatrique.

Saskatchewan

Ah! Si le temps permettait de visiter tous les membres de l'A.I.C. dans leur localité, il n'y a rien comme un contact personnel. Un autre moyen d'établir des contacts est d'assister à l'assemblée annuelle. Nous avons assisté à la 36e assemblée annuelle des Infirmières Enregistrées de la Saskatchewan, qui se tenait à Régina. L'assemblée, qui n'a durée que deux jours, a tenu l'attention de ses membres.

Pour assurer une participation plus étroite de tous, l'A.I.E.S. a demandé aux divers chapitres de présenter quelque chose d'un intérêt général. Un chapitre s'est chargé de l'étude sur le Rapport de la Structure de l'A.I.C., un autre a présenté un travail sur la coopération entre les diverses agences de bien-être, un autre offrit des rafraîchissements, etc. L'intérêt de chapitres contribuant au programme s'est manifesté par un plus grand nombre de présences.

Durant notre voyage en Saskatchewan nous avons profité de cette occasion pour visiter les endroits où sont réunies les étudiantes des diverses écoles d'infirmières afin de leur enseigner le programme d'étude centralisé. Après avoir vu l'école de l'Université de Saskatchewan, nous avons visité le centre de Saskatoon sous la direction de Mlle Gertrude James. Comme les élèves de la première classe venaient de quitter l'enseignement centralisé pour leur école respective où les étudiantes doivent recevoir un enseignement intensif sur les arts du nursing, le personnel de l'enseignement centralisé n'était pas en mesure d'estimer la valeur de l'enseignement. Tout de même si l'on juge du succès par l'enthousiasme des étudiantes et des institutrices, il n'y a pas de doute.

A Saskatoon, la visite du nouvel hôpital universitaire en voie de construction nous a révélé la réflexion apportée aux plans et bien des choses nouvelles. Le service des repas a été étudié avec soin. Après de nombreuses expériences dans la centralisation du service des plateaux, l'on veut revenir à l'ancienne formule du service des repas aux malades sur l'étage sous l'oeil du personnel infirmier. Dans ce nouvel hôpital le cours de base sera donné aux étudiantes infirmières. La directrice de l'école — Mlle Hazel Keeler — espère qu'il sera possible de préparer des infirmières pouvant répondre à tous les besoins du service des hôpitaux — urbains ou régionaux.

Une des résolutions de l'assemblée annuelle fut l'analyse du coût de l'administration des affaires de l'association — les dépenses excèdent-elles les revenus? Les infirmières de la Saskatchewan ont voté l'augmentation de la contribution à $15.

Alberta

Le grand nombre d'infirmières présentes à l'assemblée annuelle de l'Association d'Infirmières Enregistrées de l'Alberta montre bien avec quel enthousiasme elles participent aux activités du nursing. Pour la troisième fois, la réunion a eu lieu à Banff. Comme en Saskatchewan, les finances furent étudiées longuement. Les infirmières ont trouvé qu'il était nécessaire d'augmenter leur contribution à $15. L'abonnement du *Canadian Nurse* est compris dans cette contribution. Le chapitre du Banff depuis trois ans fait un gros travail dans le but de préparer le congrès de 1954.

Le départ de Mlle Rae Chittick a été souligné durant plusieurs années. L'association a bénéficié de son esprit éclairé. Comme présidente depuis deux ans du Comité de la Politique en Matière d'Education, elle a contribué aux progrès des écoles d'infirmières de cette province. Mlle Chittick a accepté la direction de l'école supérieure d'infirmières de l'Université McGill.

Lors d'une visite à l'hôpital psychiatrique de Ponoka, nous avons constaté avec plaisir que le personnel était à préparer un cours de deux semaines pour les institutrices des écoles d'infirmières. Comme il est convenu d'intégrer dans le cours de base les principes de la psychiatrie, des dispositions furent prises pour recevoir les institutrices des écoles d'infirmières et de leur illustrer, au moyen de conférences, cinéma, discussion, et démonstration, l'aspect "mental" du nursing. Ces journées d'études n'ont pas pour but d'enseigner la psychiatrie mais de démontrer comment les principes peuvent être appliqués. Comme disait quelqu'un savoir quoi dire à l'élève lorsqu'on lui demande de "réassurer" le malade? Félicitations à l'Hôpital de Ponoka et à l'Alberta!

Colombie-Britannique

Le prix des loyers augmente. Chaque association provinciale est aux prises avec le coût élevé des loyers des bureaux qu'elle occupe. L'Association des Infirmières Enregistrées de la C.-B. semble avoir trouvé une solution à ce problème et c'est très

simple — construire un immeuble et l'habiter! Lors de l'assemblée annuelle l'on autorisa l'association à acheter un terrain un peu en dehors du centre commercial et de construire. Avec sa prévoyance habituelle, l'association se propose de louer une partie de l'immeuble durant quelques années afin d'aider à payer les dépenses puis, selon les besoins, plus tard d'occuper tout l'immeuble. Bien que l'Association des Infirmières Enregistrées du Manitoba soit propriétaire de l'immeuble qu'elle occupe, nous croyons que l'A.I.E.C.B. sera la première à entreprendre des travaux de construction.

Durant notre séjour à Vancouver, nous avons visité l'Ecole d'Infirmières de l'Université de la Colombie-Britannique. La directrice de l'école — Mlle Evelyn Mallory — a pris une part active dans la préparation des plans. Les bureaux, les salles de classe, et l'outillage présentent un ensemble à la fois pratique et agréable.

La secrétaire-registraire, Mlle Alice Wright, fut l'objet d'une démonstration de reconnaissance de la part des membres de l'A.I.E.C.B. Grâce au travail de Mlle Wright et à celui de Mlle Helen Randal, première registraire, l'association a une base solide. Mlle Wright doit partir pour le Congrès International. Une montre lui fut presentée en marque d'estime.

En Traversant les Provinces de l'Ouest

Ce que nous avons vu durant ce voyage nous a inspiré les réflexions suivantes:

L'infirmière ne doit pas perdre de vue les standards de sa profession et elle doit se rendre compte de leur portée. A chaque assemblée annuelle nous avons constaté que les buts de la profession étaient énoncés et que les infirmières voulaient travailler à les atteindre.

Voici ce que disait à ce sujet Mlle Esther Paulson, présidente sortant de charge:

"Les infirmières en géneral ne se rendent pas toujours compte du rôle important que chacune d'elle joue dans l'interprétation au public des changements qui se produisent. C'est elle par son influence qui détermine le degré de respect et de confiance que le public accorde à la profession."

Chez les Nôtres

L'O.M.S. vient d'accorder une bourse de voyage d'observation portant sur les aspects de l'hygiène publique. Mlle Gabrielle Charbonneau, directrice à l'Ecole d'Hygiène de l'Université de Montréal, a été choisie. Elle visitera plusieurs pays.

Bourse Gilchrist

La Fondation Gilchrist d'Angleterre mémorial de guerre accorde des bourses d'étude aux pays du Commonwealth. Cette année le désir fut exprimé qu'une infirmière de langue française en soit la bénéficiaire. Mlle V. Leclair, diplômée de St-Jean de Dieu, a été la candidate élue. Mlle Leclair, à la suite de voyages aux Etats-Unis, est devenue une parfaite bilingue. Après avoir suivi un cours post-scolaire en psychiatrie, elle fut chargée des cours aux élèves affiliées.

Bourses de l'Association des Infirmières de la Province de Québec

Quatre bourses d'étude furent offertes aux membres de l'association. Elles furent accordées à Mlle Angeline McKenty de Sherbrooke; à Mlle Jeanne Reynolds de l'Hôpital du Sacré-Coeur, Cartierville, et à Mlle Brady de l'Hôpital St. Mary's, Montréal.

Conférence Canadienne des Ecoles Catholiques d'Infirmières

Montréal recevait les directrices de nombreuses écoles catholiques d'infirmières du Canada. Ces journées d'étude, tenues du 25 avril au 2 mai à l'Institut Marguerite d'Youville, avait pour but d'étudier les courants actuels dans le domaine du nursing et dans l'éducation des infirmières, d'élaborer la position des écoles catholiques et de formuler des directives et d'établir des plans d'action.

Parmi les sujets traités signalons: Comment développer chez les étudiantes infirmières, avec la science et l'art, le véritable esprit chrétien du nursing; la situation actuelle des écoles catholiques d'infirmières; les problèmes concernant l'éducation de l'infirmière; écoles indépendantes, écoles centrales, programme de deux ans; octrois gouvernementaux pour l'éducation de l'infirmière; l'éducation du personnel auxiliaire; et l'évaluation des écoles d'infirmières. Une autre question étudiée fut les relations avec les associations provinciales et nationale d'infirmières, etc.

Ces journées d'étude, sous l'habile direction de la Rév. Sr. Denise Lefebvre, nous n'en doutons pas aideront non seulement à l'avancement des écoles catholiques d'infirmières mais à toute la profession.

Post-Convention Tours

WHEN THE Canadian Nurses' Association Biennial Convention in 1954 *(June 7-11)* is over, your real holiday begins. You have a choice of three wonderful trips — your decision will depend on the amount of time at your disposal.

PACIFIC COAST TRIP — *5 days*

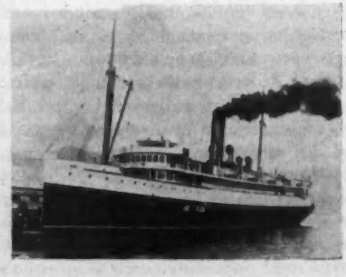
Leaving Banff at noon Saturday, June 12, go over the Great Divide, through the spiral tunnels and Kicking Horse Pass and 500 miles of unsurpassed mountain scenery to Vancouver, arriving Sunday morning in time to attend church. Twenty-four hours will be spent in this west coast city, with headquarters at the Vancouver Hotel. Sightseeing trips may be taken to Stanley Park, the Lion's Gate Bridge, Marine Drive, English Bay, Capilano Canyon, and Chinatown.

Monday morning, sail on one of the modern Princess steamers across the island-dotted Straits of Georgia to Victoria — the capital city — where you stay two days at the world-famous ivy-covered Empress Hotel, set in ten acres of gardens. Here afternoon tea is a ritual, and restful, gracious living the order of the day. Swim in warm filtered sea-water in the Crystal Gardens pool. You will have time for some interesting drives around this beautiful city, with its flowers everywhere and the well known hanging-baskets. See Beacon Hill Park, the Yacht Club, Oak Bay and Beach Drive with its magnificent vista of the Olympic Mountains and Straits of Juan de Fuca. Go further afield: visit Butchart's Gardens — 16 acres of floral wonderland — and take the Malahat Mountain Drive. There are many trips up Vancouver Island — see Nanaimo, Qualicum Beach, Cowichan Bay, and Goldstream Canyon. Wednesday afternoon return by steamer to Vancouver, in time to connect with east-bound trains.

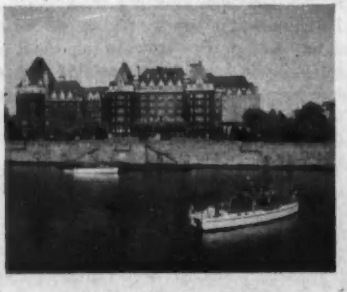
Approximate cost of transportation, lower berths (to Vancouver and return), fare to Victoria, and hotel accommodation (two in a room with bath) $80.05. Meals, transfers, sightseeing and trips not included.

CRUISE TO ALASKA — *8½ days*

Have you ever wanted to take a cruise to the top of the world — to see the midnight sun, the Klondyke and Yukon, the Trail of '98? Land of caribou, glaciers, magic twilights and incredibly long days, where seasons are jumbled and flowers grow over-size? The ship itself is a floating palace noted for its fine accommodation and cuisine, its sun-bathed decks and wide-windowed observation lounges. Sail up the Inside Passage, with all the pleas-



The Princess Louise



Empress Hotel, Victoria

ures of an ocean voyage, but most of the time close enough to land to enjoy majestic scenery, deep-cut fiords, picturesque fishing villages and Indian settlements.

The ship stays in Skagway about 36 hours — long enough to give you a choice of two side-trips. From your parlor-car seat on the White Lass and Yukon Railroad you can trace the tortuous route taken by the prospectors on the trail of '98. At Carcross take the steamer across Lake Tagish to the end of West Taku Arm and the lovely wilderness garden of Ben-my-Chree (this trip costs $45).

or

Instead of taking the steamer at Carcross, you may continue by rail to Whitehorse, Yukon, at a cost of $30.50. For those who prefer to remain on the Princess Steamer while in port at Skagway, there is a charge of about $10.00 to cover meals and berth.

Returning from Skagway, calls are made at Juneau, the capital of Alaska, famous for its museum and curio shops; Wrangell and its totem poles; Prince Rupert and Ketchikan, arriving back in Vancouver in the morning in time to make connections with homeward-bound trains.

The trip from Vancouver to Skagway and return covers 2,000 miles, takes eight and a half days, and the minimum first-class fare, including meals and berth, is $165.66.

HAWAII — PACIFIC PARADISE
3 days

In an enchanted tropical setting for the holiday you could not have until now, just ten hours by air from Vancouver, lie these lovely islands in the warm Pacific. This is a golden opportunity to visit a world-famous playground that travellers remember above all others — happy, unhurried, carefree Hawaii! Brilliant sun on palm trees, soft breezes over the coral reefs, and surf breaking on white sands! A glamorous ten-day holiday that will be your dream of a perfect vacation come true.

Leaving Vancouver Sunday morning you can be in Honolulu that evening. No other city offers such a colorful welcome to its visitors — the custom of giving leis of exotic flowers makes one's arrival and departure particularly exciting. Here you will stay at still another luxury hotel — the Moana. Although Honolulu is the crossroads of the Pacific for ships and planes, many touches of the Orient still remain

Matson Lines Photo

View of Royal Hawaiian Hotel

—quaint bazaars and shops, temples, tea-gardens, and strange music. Here you can swim at Waikiki Beach, watch the bronzed surf-riders and torch fishermen, go out to the undersea coral gardens in glass-bottomed boats, or just loaf in the sun. Visit pineapple and sugar plantations, orchid farms, banana and coconut groves; eat at Trader Vic's or the Beachcombers; attend a *luau* (native feast) where food is wrapped in leaves and cooked on stones in the ground; taste poi; and be entertained by hula dancers.

Take a Circle Tour up the Nuuanu Valley to the Pali, the scenic masterpiece of Oahu, and visit the exquisite Mormon Temple, often called Hawaii's Taj Mahal. Another day, drive up Mount Tantalus for the breath-taking panorama from Diamond Head to Pearl Harbor. Stop at Punchbowl, an extinct volcano now used as a war cemetery. See Kuapa Pond, said to have been built by the pixies. Drive through old lava flows from Koko Crater and see the Blow-hole, where the sea is forced up through tiny holes in the lava and creates miniature geysers.

Everywhere there is a profusion of tropical flowers and foliage — oleanders, hibiscus, bougainvillea and paradise flowers; bamboo, breadfruit, Pride of India and mango trees. Have luncheon under the well known banyan tree at the Moana Hotel and stay for the broadcast "Hawaii Calls."

On Wednesday say *Aloha*, accept more leis, and take the big luxurious Empress of the Air back to Vancouver, after a never-to-be-forgotten holiday.

Cost from Vancouver, including air fare, taxis to and from airport in Honolulu, hotel accommodation (two in a room with bath) and three sightseeing trips (Circle Island, Mount Tantalus and Koko Crater) — $380.25.

Note: First-class fare and lower berth, Banff to Vancouver and return — $50.30 — including steamer to Victoria.

All fares and times shown are those of the present and are subject to change.

Swim indoors or out! At the Biennial Banff Springs Hotel, June, 1954.

Student Nurses

Panhysterectomy

IRENE NORDWICH

MISS BURT, AGED 35, was admitted to the ward on February 17 bleeding profusely from the vagina. There was no complaint of any pain. Her abdomen was protruding considerably in the centre and a large mass could be palpated in the lower abdomen. Her face and skin generally appeared very pale. Temperature was slightly elevated to 99°, pulse rapid, of good quality, B.P. 110/80.

Diagnosis — Pre-operatively: severe anemia, fibroids of uterus, ovarian cyst, myocardial hypoxia. *Post-operatively:* Leiomyofibroma permagnum uteri, chronic salpingitis (tube labyrinth) and right perisalpingitis. Paratubal cyst of Kobelt, adhesions around ovary, tube and adjacent right uterine corn.

DEFINITION

Myomatous or fibroid tumors of the uterus are benign tumors, arising from the muscle tissue of the uterus. They are very common, occurring in at least 40 per cent of all women. They develop slowly between the ages of 25 and 40 and often attain a large size after this period. They produce symptoms of pain, backache, constipation, and urinary trouble due to pressure on surrounding organs. They also often cause menorrhagia, metrorrhagia, and even sterility.

SOCIAL HISTORY

Since the age of 15 Miss Burt has been working in a department store where her mother is a manager. She considers her tasks fairly easy and states that the work was in no way hazardous to her health. She plans to return to the same job as soon as she has finished convalescing.

Miss Nordwich is a student nurse at the Misericordia General Hospital, Winnipeg, Man.

Miss Burt lives in her mother's home together with her younger sister and aunt. Since all members of the family are working, they have a full-course dinner daily at home. Their breakfast consists often of toast, coffee, and a cigarette. Lunch is frequently taken at a snack bar downtown. They have a preference for a menu that is rich in highly spiced meats. Fruits are taken in moderate quantities but very few vegetables. She is very fond of milk and has always taken a lot of it.

The patient has no major financial responsibilities towards her family. Four out of her five brothers and sisters are married and all of them are independent. Her salary allows a comfortable living on a moderate basis. Costs of hospitalization were largely covered by Blue Cross and she is in no danger of losing her job due to a long absence.

PERSONALITY

This is a young, pert female of average intelligence. She appears to be quick tempered and quite outspoken. Since she noticed the external changes of her body rather early, she became quite conscious of it. Sometimes her family put a false interpretation of the increasing volume of her abdomen. This resulted in a rather aggressive-defensive mood that manifested itself sufficiently during her first days in hospital. She did not attempt to consult a doctor but ignored her condition for almost two years, merely wearing a tight girdle until a severe hemorrhage forced her to action. Underlying her delay might have been the fear of losing the ability to have a normal married life and motherhood. After the patient had a lengthy discussion of her condition with her doctor, her attitude changed markedly. She became very cooperative and following the

operation made a very speedy recovery.

Medical History

Onset: Two years ago Miss Burt was hospitalized for an appendectomy. Afterwards her abdomen was quite distended. The distention decreased very little and presently she noticed a firm elevation of the lower abdomen that gradually increased. She interpreted it as a result of the previous operation and wore a tight girdle. No pain or discomfort of any kind was noticed. The menstrual periods were regular, not excessive in flow. Early in February profuse bleeding started. Miss Burt stayed in bed for four days. As the bleeding became persistent and large clots were expelled, her mother called the doctor, who arranged for an immediate transfer to the hospital. Occasional cramps in lower abdomen during the last period of bleeding was the only pain experienced.

Laboratory findings—Hematology: R.B.C. 2,420,000 (normal 4,000,000 — 5,000,000); hemoglobin 36% (normal 80-100%); color index .75 (normal 1.0); W.B.C. 6,550 (normal 5-9,000); morphology — marked anisocytosis, fair degree hypochromia.

Urinalysis: Albumin, light trace; R.B.C.; loaded with bacteria (in normal urine none should be present).

X-rays: Chest — great vessels slightly broadened, otherwise negative. Abdomen — a soft tissue mass 6 inches in diameter arises from the pelvis in the mid-line. No definite fetal structure is seen within it.

Nursing Care

Environment: In preparation for major abdominal surgery, pleasant environment is an important factor in building up the patient's mental and physical ability to meet the coming strain. Therefore clean, well ventilated, cheerful accommodation should be provided with every possible comfort and privacy to ensure complete relaxation and rest.

Miss Burt was placed in a four-bed ward where the temperature, humidity, and ventilation had to be adjusted to suit all of the patients. The room was kept at between 63-71°. No steam

A NEW ORANGE JUICE FOR BABIES...

whether cup, bottle, or spoon fed

Guaranteed Vitamin C value → Oranges are specially selected for high ascorbic acid content. Carefully pasteurized to retain a *minimum* of 40 mg/100 cc.

Easy to digest → Special processing results in negligible amounts of peel oil... never more than .010%.

Highly acceptable to babies → Made from tree-ripened unblemished oranges. Flavor-controlled with dextrose added when necessary to adjust sugar-acid ratio for year-round uniformity. Attractive natural fresh-fruit color.

Convenient for young mothers → Ready to serve. Extra finely strained and homogenized to go easily through regular nursing-bottle nipples.

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Gerber-Ogilvie Baby Foods, Ltd., Niagara Falls, Canada

kettles were used. On very cold days portable electric heaters provided additional warmth. Movable screens to secure privacy were used for bath, perineal care, doctors' examinations, and other procedures.

Psychological approach: Since the patient was very sensitive about any possible misinterpretation of her condition, and rather apprehensive in giving details, questions had to be framed with the utmost tact and with a matter-of-fact crispness, avoiding comments. On the other hand, constant reassurance was necessary with regard to her physical condition after the operation. It became evident that she had little knowledge of practical health measures and popular medicine found so commonly today in lay people. The nurses were called upon for a lot of health teaching. This was well received by the patient and smoothed her relationship with the nurses.

Personal routine care: Nursing treatments consisted of routine ward care with bed-bath, special care to perineum, and frequent breathing exercises. Careful watch was kept over her bowel and urinary output and fluids were forced, up to 3,000 cc. daily.

The Operation

The doctor's first concern was to stop the vaginal bleeding and build up the blood. For that purpose the foot of the bed was elevated and the patient received eight bottles of blood over a period of a week. After that her hemoglobin went up to 70%. After a vaginal and rectal examination, the date for her hysterectomy was set.

A total hysterectomy and removal of the right ovary was performed successfully. When she returned from the operating room, she was deeply unconscious, with an indwelling catheter, her pulse and blood pressure remaining at a normal level. Morphine gr. ⅙ was given for pain for 48 hours. Her temperature rose on first post-operative day to 100° but dropped rapidly and remained normal thereafter.

Miss Burt received penicillin, 1 cc., for four days. Foley's catheter was

removed on fourth day and there was no difficulty in micturition afterward.

Soon after regaining consciousness Miss Burt moved about well, dangled her feet over the side of her bed on the evening of operation and was out of bed the next afternoon. On the second post-operative day she was walking in the room and after that was up as she chose. No complications of any kind set in. On the third post-operative day a cleansing enema was given with good results.

Diet: Pre-operatively, Miss Burt ate the full ward diet. Post-operatively, she was given fluids the first day, soft solids the second day, then normal ward diet with additional fluids.

Prognosis

After the operation Miss Burt's mental attitude was very positive and optimistic. She was cooperative, interested in her surroundings and the fellow-patients in her room. She read a great deal. Her family, who gave signs of great concern and affection, certainly contributed to a quick recovery. She wants to return to work as soon as possible and plans eventually to marry.

Aside from her inability to bear children, Miss Burt's physical capabilities are normal. In the doctor's opinion, no hormone preparations will be required as a supplement. No physical rehabilitation is necessary. Possibly if the tumor had been given surgical attention earlier, the uterus might have been saved. However, this cannot be proved definitely. The laboratory reports of microscopic examinations of the specimen from the operating room revealed several pathological processes in the reproductive organs.

Conclusion

The study of this case has given me a better all-round picture and understanding of this particular condition. The interwoven mental and physical reactions of the patient and their influence on her condition teach anew that we have a complex personality to deal with, not just "an interesting case."

Book Reviews

Handbook of Diet Therapy, written and compiled by Dorothea Turner, for the American Dietetic Association. 138 pages. Published by the University of Chicago Press and distributed by the J.B. Lippincott Co. (Medical Arts Bldg., Montreal 25) by arrangement. Revised edition, 1952. Price $3.50.

Editor's Note: On publication of a review of this book on page 478 of our June issue, we are sorry that the name of the American publishers was omitted.

Aids to Psychology for Nurses, by Norah Mackenzie, M.A. (Oxon.), F.C.S.T. (Hon.). 136 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $1.00.

Reviewed by Morna Kenny, School of Nursing, University of Western Ontario, London.

This text is one of a group of books in the Nurses' Aid Series, "designed to provide a series of textbooks covering the various fields of knowledge required by the modern nurse . . . each volume . . . designed as a complete textbook in itself . . ."

As explained by the author, this particular text is written to follow the course in elementary psychology laid down in the syllabus for the curriculum of Training of the General Nursing Council (England). The book consists of ten chapters whose titles clearly indicate the contents of each. These are as follows: The Innate Endowment; Acquired Behavior; Character; Learning, Thinking and Reasoning; Development in Society; The Family; Unconscious Mental Activity; Mental Mechanisms; Common Effects of Illness; The Nurse-Patient Relationship.

Each chapter is clearly divided into subheadings and is followed by a list of questions or topics for discussion. The text is devoid of a bibliography except for a few books mentioned briefly in the foot-noting and used by the author mainly for definitions. As it was the author's intention to avoid technical terminology, there is no glossary. There is no mention in the body of the text of any experimental work which might help to illustrate a point but examples are

taken from everyday life and the students' own experiences.

Chapter 9 — Common Effects of Illness — is very important for all nurses to absorb and understand. Chapter 10 — Nurse-Patient Relationships — though superficial, and in some parts questionable, has some good points. One of the questionable statements is: "There will always be some difficult patients but the majority will be amenable to prestige." Surely the sick patient has a right *not* to worry about the prestige needs of the nurse. The participation of the patient can be better obtained through the warm, permissive attitude of the nurse than through reliance upon any such superficialities. The nurse who worries about maintaining prestige is not likely to be either warm or permissive. To be of much use to maturing students, the final chapter on Nurse-Patient Relationships would have to be enlarged considerably, or omitted altogether, and other texts used instead.

In the opinion of this reviewer, much more stress could have been placed on normal growth and development, as the understanding and acceptance of adult behavior in stress situations depends so much on a thorough knowledge of this aspect of psychology. This text might conceivably be used as a quick reference book for preliminary students.

News Notes

ALBERTA

VIKING

At a regular meeting of Viking Chapter Mrs. Sorenson presided in the absence of Mrs. Dearing. Mrs. Hafso was hostess for the meeting, the chief item of business being plans to get the proposed refresher course under way. The guest speaker, Mrs. Kleen, gave an interesting talk on "Social Service."

LAMONT

Public Hospital

The annual luncheon given by the Archer Memorial School of Nursing Alumnae Association was held in honor of the graduating class at Elk Island National Park in May. Mrs. A. Cowan, president, welcomed the 77 guests. The guests of honor included the 14 graduates, Miss M. S. Simpson, guest speaker, and the Rev. J. E. and Mrs. Nix. Dr. Weatherilt, on behalf of K. Bartleman, now a resident of Hawaii, presented a lei of orchids to the 1953 class and a corsage of orchids to Marie Young, superintendent of nurses. J. Graham introduced Miss Simpson to the group and Dr. Dobson extended a vote of thanks to her

for her inspiring talk. Dr. M. A. R. Young, medical superintendent, also spoke briefly to the graduates. D. Mitchell was convener for this event.

At the graduation exercises, pins, diplomas, medals, and prizes were received from Miss Young, N. Davidson, Dr. J. A. Alton, and Mr. N. Buchanan. The guest speaker was Dr. Andrew Stewart, president, University of Alberta. Dr. Dobson gave a short résumé of some of the recent discoveries and treatments of diseases. Dr. Sommerville, Deputy Minister of Health for Alberta, also addressed the new class.

T. Kimura, E. Jones, P. Bell, and L. Poleschuk were among the prize winners.

BRITISH COLUMBIA

KAMLOOPS

Attending the annual meeting of the R.N.A.B.C. from the Kamloops-Tranquille Chapter were: D. Resitch, M. Rowles, E. M. Moody, C. C. Sinclair, M. Davies, and Mrs. E. C. Nicholson.

In honor of the graduating class of the Royal Inland Hospital a buffet dinner was held and a pleasant social evening enjoyed. Coronation spoons were presented to each graduate and a gift to Miss Sinclair. A solo was rendered by V. Demmon and the group enjoyed a sing-song.

Two prizes will be awarded annually to student nurses presenting the best nursing care study, it was decided at a regular alumnae meeting. At this time, Miss Rowles discussed the C.N.A. Structure Study.

NELSON

Members of Nelson Chapter were hostesses to the West Kootenay District executive when $100 was voted towards the expenses of Flora McLean, chapter president, to attend the I.C.N. Congress in Brazil. New Denver will be the locale for the fall meeting.

Chapter members assisted at the Red Cross Blood Donor Clinic and with the Civil Defence Alert Day program. A report of the R.N.A.B.C. annual meeting was given at a recent chapter meeting by Miss McLean. Fifty dollars and the proceeds from a raffle held by the chapter were also given to Miss McLean for her expenses to Brazil.

A shower was held for a recently married member — M. (Parker) Dickinson.

VANCOUVER

St. Paul's Hospital

The alumnae association held a reception in May in honor of Sr. Columkille who is retiring as director of the school of nursing, to be succeeded by Sister Denise Marguerite. Many regrets were expressed, as Sr. Columkille has been active in varied nursing capacities in the hospital and the community and is widely beloved by those who have worked with her. (See Nursing Profiles this issue.)

The balance of the Bursary Fund is $1,089, with one bursary to be given in June. Alumnae members active at the annual meeting of the R.N.A.B.C. were: Mmes D. Cowper, Banner, B. Lane, D. Murray, Miss E. Kunderman.

VICTORIA

Mrs. E. Worsley has replaced Mrs. H. R. Levis, who has retired, as the nurse serving with the leper colony on Bentinck Island.

MANITOBA

WINNIPEG

Misericordia Hospital

The annual dinner of the alumnae association, carrying out the Coronation theme in place cards and decorations, was ably arranged by Mmes E. McLaren and V. McCullough, with Mrs. Cutts acting as Mistress of Ceremonies. A hundred and three members were present, including several from out of town.

The election of officers for the coming year resulted as follows: Honorary president, G. Thompson; president, M. Dyck; vice-president, Mrs. E. McLaren; recording and corresponding secretaries, Mmes J. McTavish, P. Ireland; treasurer, Mrs. P. Buerket. The following members are also serving in various capacities: Mmes R. Smith, D. Cutts, M. Cruden, H. Copeland, I. Stewart, Misses E. Bannatyne, M. LaCroix, S. Boyne, K. Law.

NEW BRUNSWICK

MONCTON

Moncton Hospital

A summer home at Shediac Cape has been accepted for the nursing staff by the hospital board. It is the gift of the chairman, Leonard Lockhart, and arrangements have been made to have Mrs. G. O. Taylor act as house-mother. It will permit nurses spending holiday periods, as well as visiting it for meals, swimming, etc. The centre will be operated under direct control of the school of nursing.

NOVA SCOTIA

HALIFAX

Flight Lieut. M. J. Fitzgerald was presented recently with the United Nations Service Medal for service on the Korean Airlift. She was one of the first two women to receive the decoration, which was earned while on operational duties as flight nurse with the U.S. Air Force, caring for the sick and wounded returning from Korea.

TRURO

The Ladies' Auxiliary of the Colchester County Hospital has awarded four scholarships of $100 each "to assist girls entering training and to help maintain the high standard of nursing in Nova Scotia." The recipients are: M. Stewart, Malagash; H. Johnson, Upper Stewiacke; I. Hoare, Man-

ganese Mines; E. Bowman, Truro. The Auxiliary has been a very effective agent in interesting students in nursing.

ONTARIO

District 1

Chatham

Correction — On page 320 of the April issue of the *Journal*, the following item appeared concerning the Community Nursing Registry: "Reports revealed that during 1952 the registry received 1,772 requests for graduate nurses but due to the shortage of help 1,400 requests went unfilled." It should have read: ". . . *400* requests went unfilled."

District 4

Niagara Peninsula Chapter

The members of the chapter were hostesses at a picnic at Fort George, for the graduating classes of the Greater Niagara Falls General Hospital and the Mack Training School, St. Catharines. Three of the student nurses were presented with prizes for essays entitled "What the R.N.A.O. Can Do for Me."

Oakville

Keeping a hospital in the forefront of community thinking is a full-time task that necessitates taking advantage of every opportunity to tell the hospital story to the general public. The Junior Chamber of Commerce always donates booth space to the Oakville-Trafalgar Memorial Hospital at the time of their Home and Industry Show.

Photo by Charles Osland, Oakville, Ont.

This year an oxygen machine, operating table, and surgical instruments were on display as well as pictures of all nurses serving at the hospital. A local druggist loaned his mannequin which was dressed as an O.R. nurse (*see cut*). The pictures of the nurses created special attention among both the older and younger set. It is the intention of the hospital to use these photos as a window display.

District 5

Oshawa

General Hospital

Under the direction of the president, A. Schaan, the alumnae association recently

gave a banquet and dance in honor of the class of 1953. An honorary life membership was awarded to Dr. Adelaide McLaughlin and nine 25-year life memberships were also presented. Accompanied by Mrs. G. Fleming, Mrs. G. Baker sang several vocal numbers. Mrs. R. S. McLaughlin gave an inspiring address, following which dancing was enjoyed, with A. Schaan, M. Bourne, director of nurses, and Mrs. McLaughlin receiving the guests.

TORONTO

Western Hospital

The alumnae association held a banquet in May in honor of the 62 nurses who will be the first to graduate under the modified course (two years plus one year internship) under the direction of Gladys Sharpe. The toast to the class was proposed by Mr. E. C. Scythes, a member of the Board of Governors, the guest speaker being Dean R. O. Hurst, Dean of Pharmacy, University of Toronto. Among the honored guests were the first two graduates of the school — Mrs. I. P. MacConnell (1898) and Mrs. Frances MacLean (1899).

DISTRICT 7

PERTH

Over 70 nurses attended the June meeting of the district held at Merrywood Camp for Crippled Children. The Perth Chapter was in charge of the program with Sr. Mantle, district chairman, presiding. The guest speaker was Miss Oliphant, director of nursing for the Ontario Society for Crippled Children, who gave a talk on the work of the camps and how they are financed. She also spoke of Variety Village, a school for crippled boys who have passed Grade VIII. A delightful lunch was served to the guests on the lawn when a skit, given by the children, was also enjoyed.

BROCKVILLE

General Hospital

Activities of the alumnae association during the past months included: Annual bazaar, Pot Luck Supper, tea and home-cooking sale, and telephone bridge, the objective being to raise funds for the purchase of a projector for the classroom.

Twenty-six graduates were present at the dinner in honor of the 1953 class when Canon H. K. Coleman spoke on "Requisites for Happy Living." A final get-together until the fall was planned in the form of a picnic.

The following officers are now serving on the executive: Honorary presidents, Miss Shannette, Mrs. White; president, Mrs. H. W. Greene; vice-presidents, R. Carbery, Mrs. M. Derry; secretary, Mrs. R. Reynolds; treasurer, Mrs. W. Stewart. The following are on the various committees: Misses V. Preston, Kendrick, Mmes J. Reynolds, H. Bishop.

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

To take place on **October 21, 22 and 23, 1953,** at **Halifax, Yarmouth, Amherst, Sydney,** and **New Glasgow.** Requests for application forms should be made at once and forms MUST BE returned to the Registrar by **September 21, 1953,** together with the following: (1) Birth Certificate; (2) Provincial Grade XI Pass Certificate; (3) Hospital Diploma; (4) Fee of $10.00.

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations and is within six (6) weeks of completion of the course in Nursing.

NANCY H. WATSON, R.N., Registrar
The Registered Nurses' Association of Nova Scotia
301 Barrington St., Halifax, N.S.

SMITHS FALLS

Nurses of the district combined recently to honor Amy Church on the occasion of her 50th year in active nursing. Miss Church, who graduated in 1903 from Brantford General Hospital, was welcomed at a tea held at the home of Mrs. D. Carson. A bouquet of 50 tulips was presented to the honored guest by Mrs. A. Leach and she also received a wrist watch, the gift of those present. Other senior members of the nursing profession at the tea were Margaret Moag and Jennie Taggart. Helping with the serving were: Mmes P. G. N. Stewart, W. Slack, A. Wagner, R. Clark, M. Webster, C. Hughes, J. R. Blackburn, Miss M. Findlay. Piano selections were played by Mrs. C. B. Haladay.

DISTRICT 10

PORT ARTHUR

St. Joseph's General Hospital

At a recent dinner meeting of the alumnae association, which was attended by 54 members, bridge and canasta were played, the prize winners being Mmes E. B. C. Hague and I. Purvis. Edith Fenton, public relations secretary of the R.N.A.O., was guest speaker for the following meeting. Introduced by Sr. Patricia, Miss Fenton spoke on "Nursing Organizations" and was thanked by Mrs. G. Phillips. B. Zorzes is convening the arrangements committee for the annual Nightingale Ball.

QUEBEC

MONTREAL

General Hospital

The cornerstone of the new hospital was laid on May 2. Copies of the *Hospital Bulletin* for May noted the progress of the building development and other interesting events and were sent to all alumnae members.

Forty graduates and students in uniform attended the inaugural Francis Shepherd Memorial Lecture delivered by Sir Sydney Smith of Edinburgh University.

At the graduation exercises of the 63rd class, presided over by W. S. M. McTier, the address was given by Dr. Campbell Gardner, prizes presented by Mrs. Andrew Fleming, M.B.E., while candidates for diplomas and medals were presented by Martha MacDonald. Recipients of prizes were: F. Major, E. B. Rau, C. Lavallée, R. F. Donald, H. D. Taylor. A total of 59 students were in this class. Archdeacon Gower-Rees was the speaker at the alumnae dinner held in honor of the new class.

Grateful thanks are extended to The T. Eaton Co. for the loan of three television sets on Coronation Day — one for Ward E where all ambulatory patients were assembled, two for the nurses' and internes' residences. A successful bridge was held by the alumnae at the Central Division which netted $360 for the Nora Livingston Fund.

I. Riley and B. Chalmers attended the Science in the Curriculum Workshop held at McMaster University School of Nursing, Hamilton, in May. V. Crouse is now clinical supervisor in the O.R., M.G.H. J. Lisson, S. Welling, and E. Mooney have resigned to be married.

McGill School for Graduate Nurses

At the annual meeting of the alumnae association, Mr. Westbury, a speaker from the office of the Joint Hospital Fund of Montreal, explained the importance of and reasons for the third stage of the campaign for the construction work on the Montreal General, Children's Memorial, and Royal Edward Laurentian hospitals.

Ann Peverley, assistant professor at the School, has been selected as the only Canadian to be sent on a World Health Organization team to study nursing conditions in various parts of South America.

Royal Victoria Hospital

R. Fleming is head nurse, Ross 5, replacing E. Comte who resigned. L. Wallace is assistant head nurse, Ross 4. D. O'Brien and H. Grbac have joined the O.P.D. staff, M. Lepage having resigned. A. Eaves is with the Miller Bay Indian Hospital, Prince Rupert, while M. Shaw is on the V.O.N. staff, Digby, N.S. M. Singer and A. Pincott are nursing in Bermuda. L. Cox is alternate head nurse, Neurosurgical Unit, Hartford Hospital, Conn. M. Hudson, who has been home on leave, will return shortly with WHO to New Delhi, India. Recent visitors to the hospital have been W. Chute on leave from India, L. Pidgeon, and M. Swinton.

SASKATCHEWAN

SASKATOON

City Hospital

In honor of Mrs. T. Yourk, a tea was held recently, at which appreciation of her faithful service was acknowledged by the gift of a combination sandwich and waffle iron.

New additions to the staff include the following graduates: M. Talmay, D. Rudman, B. Long, B. Riske, C. Sawatsky, Mrs. E. Hirsch.

St. Paul's Hospital

It was a pleasure to welcome visitors from the hospital administrators convention held at the University of Saskatchewan. M. Mackenzie, nursing arts coordinator, represented St. Paul's at the National League of Nursing convention held in Cleveland. L. (Johnston) Blythe, a 1925 graduate, was a recent visitor to the nurses' residence.

BERMUDA

King Edward VII Memorial Hospital

The recent graduating class of the school of nursing consisted of the following: Dorothea J. Crawford, Blackville, N.B.; Florence M. Headley, Toronto, Ont.; Mary E. Tingley, Thistletown, Ont.; Marybelle MacG. Jenkins, San Francisco. Miss Tingley was valedictorian, pins were presented by Lady Hall, and diplomas by His Excellency the Governor.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Supt. for 45-bed, well equipped hospital. Salary: $230 per mo. with full maintenance, including apt. in adjoining nurses' residence. Apply Sec.-Treas., County of Bruce General Hospital, Walkerton, Ont.

Supt. of Nurses. Expansion program to 100-bed hospital. Teaching or clinical supervision certificate helpful but not essential. Apply Supt., Norfolk General Hospital, Simcoe, Ont.

Asst. Director of Nursing immediately for 150-bed General Hospital for experienced person; degree or certificate preferred. Also **Night Supervisor & Asst. Night Supervisor.** Salaries as recommended by the Ass'n. of Nurses of the Province of Quebec. Apply Director of Nursing, Reddy Memorial Hospital, 4039 Tupper St., Montreal 6.

Consultant Nurse (hospital administration) for Province of Manitoba. To act in advisory capacity to matrons & boards of general hospitals & medical-nursing units in Manitoba with respect to nursing & other administrative problems. Qualifications: Registered Nurse with post-graduate study related to hospital supervision & administration & some practical experience in small hospital administration. Headquarters will be located in central offices at Winnipeg. Considerable travelling throughout province, with expenses, will be required. Pay range: $3,180-3,780 per annum. This position offers full Civil Service benefits, including liberal sick leave, 3 wks. vacation with pay annually & pension privileges. Apply Manitoba Civil Service Commission, 247 Legislative Bldg., Winnipeg, Man.

Instructor of Nursing, Science Instructor & Clinical Instructor. Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

Operating Room Supervisor & Asst. Supervisor for Operating Room of 464-bed hospital — no obstetrics or pediatrics. Apply, stating qualifications & salary expected, Director of Nursing, Victoria General Hospital, Halifax, N.S.

Night Supervisor for active treatment Tuberculosis Hospital of 150 beds. Starting salary: $200 per mo. with full maintenance for 7-7 shift. Apply, stating full details of training & experience, Supt. of Nurses, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Que.

Caseroom Supervisor for 30-bed Obstetrical Unit. Previous experience considered. 44-hr. wk. For further particulars apply Director of Nursing, General Hospital, Belleville, Ont.

Night Supervisor for 100-bed hospital. Apply, giving experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

Registered or Graduate Nurses for 65-bed hospital. Salary: $150 per mo. plus full maintenance. Very pleasant surroundings near lake. Good time off. 4 wks. vacation. Starting 44-hr. wk. in Sept. Apply Supt., Alexandra Marine & General Hospital, Goderich, Ont.

HAMILTON GENERAL HOSPITAL

The **Hamilton General Hospital School of Nursing** invites immediate applications for:

(a) ***Operating Room Dept.*** — Staff and Graduate Floor Duty.

(b) ***Supervisors and Clinical Instructors:***

(i) Medicine. (ii) Surgery. (iii) Gynaecology.

(c) ***Graduate Floor Duty Nurses.***

• General Hospital • 900 beds • 300 students • Opportunities for advancement

For further information write:

Director of Nursing, General Hospital, Hamilton, Ontario

Supervisor for Out-Patient Dept. & Asst. Nursing Arts Instructor for Civic Hospital, Ottawa, Ont. Good personnel policies. Pension plan after 2 yrs. Apply Director of Nursing.

Public Health Nurses (qualified, experienced). Salary schedule: $2,400-3,100 depending on experience. Annual increment $100. Pension plan. Car provided or car allowance. Apply Dr. C. M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

Public Health Nurses immediately for Athabasca Health Unit — **Senior Nurse (1) & Asst. Nurse (1).** Salary at Alberta scale plus $20 per mo. bonus. Pensionable. Cars available. Modern town with pop. of 1,350. Apply Dr. E. M. Rowland, Athabasca Health Unit No. 18, Athabasca, Alta.

Public Health Nurse for general program in urban centre of 27,000. Minimum salary: $2,400 per annum. 5-day wk. — 8:45 a.m.-5:00 p.m. Lunch 1¼ hr. Employment benefits include: Pension plan, sick leave, 3 wks. vacation. Must be professionally qualified & interested in municipal public health. Apply Mr. Norman T. Dawe, Personnel Officer, Westmount City Hall, 4333 Sherbrooke St. W., Montreal 6, Que.

Registered Nurses (2) for General Duty. Salary: $160 per mo. plus full maintenance. 8-hr. day, 5½-day wk., rotating shifts. Also **Trained Aide (1).** Salary according to experience & training. Apply Saugeen Memorial Hospital, Southampton, Ont.

Registered Nurses for East Windsor Hospital, Windsor, Ont. New management, excellent working conditions. Starting salary: $220 per mo. plus free Fringe Benefits of hospitalization, medical care & life insurance. Apply Dr. John Nettleton, Medical Supt. or Miss Mary Shand, Reg. N., Director of Nursing.

Nurses interested in care & rehabilitation of those patients in later years of maturity. Starting salary: $240 per mo. 8-hr. day, 40-hr. wk. 3 wks. vacation. 6 paid holidays. New hospital affiliated with Western Reserve Medical School & associated with University Hospitals. Apply Director, Benjamin Rose Hospital, 2073 Abington Rd., Cleveland 6, Ohio.

Registered & Graduate Nurses for General Duty in new hospital (35 beds — 12 bassinets) to open approx. Oct. 30. 25 miles east of Toronto. New nurses' residence. Apply stating experience, references, etc., Supt., General Hospital, Ajax, Ont.

Operating Room Nurse for modern 100-bed hospital. Gross salary: $225 plus $5.00 for call plus $10 for P.G. or credited experience; less $52.50 maintenance. Non-B.C. Registered Nurses receive $10 less. Annual increments. Contract in conformity with R.N.A.B.C. personnel practices. Apply Supt. of Nurses, Chilliwack Hospital, Chilliwack, B.C.

Registered Graduate Nurses for Obstetrical, Medical & Surgical Units. Extra remuneration for 3-11 & 11-7 shifts. Cumulative sick time. Blue Cross Plan available. For further particulars apply Director of Nursing, General Hospital, Belleville, Ont.

Registered Nurses for General Duty, Caseroom & Eye Ward of 500-bed General Hospital. 5-day wk. & excellent personnel policies. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

Temporary residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Graduate Nurses immediately for **Operating Room; Surgical, Medical & Obstetrical Staff Nurses.** Salary for O.R. nurses, $275; staff nurses, $245 plus $10 differential for evening & night shifts. Semi-annual & merit increases. 40-hr. wk. Paid vacations, sick leave & holidays. Rooms available in nurses' home at $10 per mo., including linens, cooking & laundry facilities. Apply Director of Nurses, Valley Community Hospital, 1798 Garey Ave., Pomona, California.

Graduate Nurses (2) for 23-bed hospital. Salary: $180 per mo. with full maintenance. Increments of $5.00 per mo. every 6 mos. 48-hr. wk. 3 wks. annual holiday, sick leave & statutory holidays. Apply Sec.-Mgr., Union Hospital, Nokomis, Sask.

General Duty Nurses by early Sept. for United Church of Canada hospital, 300 miles north of Vancouver on B.C. coast. Salary: $210 per mo., less $40 for board, room, laundry of uniforms. 2 annual increments of $5.00 per mo. Sick time, 1½ days per mo. cumulative. 1 mo. annual holiday plus 10 days in lieu of statutory holidays. Transportation to Bella Bella refunded after 1 yr. Apply Matron, R. W. Large Memorial Hospital, Bella Bella, B.C.

Registered Nurses for General Duty for 150-bed Tuberculosis Hospital. Straight 8-hr. duty. Salary range: $130-145 with maintenance or $170-185 per mo. living out. Apply Supt. of Nurses, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Que.

Nurses (male & female). Also **Dietitian & Asst. Supt.** Apply, stating qualifications, experience, salary expected, Supt., Lady Minto Hospital, Cochrane, Ont.

Asst. Supt. Experience in teaching preferable. Apply Supt., Prince County Hospital, Summerside, P.E.I.

Asst. Director of Nursing Service & Education for active 200-bed hospital in B.C. Interior. 60 students. Good personnel policies & salary. Also **Science Instructor & Nursing Arts Instructor** for Fall class. Good laboratory facilities & new teaching equipment. For information apply Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

Asst. Director of Nursing for 400-bed hospital with school of 200 students. Full information on application to Director of Nursing, City Hospital, Saskatoon, Sask.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Science Instructor for Training School of 40 student nurses by Sept. 1. For full particulars apply Supt. of Nurses, Soldiers' Memorial Hospital, Orillia, Ont.

Educational Director for School of Nursing of 200 students. Post-graduate experience preferred. For further information apply Director of Nursing, City Hospital, Saskatoon, Sask.

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

District Supervisor for City of Ottawa. Generalized public health nursing program under Director of Public Health Nursing. Blue Cross benefits & pension fund. Minimum salary: $2,640 with generous Cost of Living Bonus & with allowance for experience. Apply Dr. J. J. Day, Medical Officer of Health, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Public Health Nurses (2) for Lennox & Addington County Health Unit. Minimum salary: $2,500. Adjustments made in salary for experience. Annual increment. Cumulative sick leave. 4 wks. vacation. 5½-day wk. Car allowance on a mileage basis & loan if necessary for purchase of car. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Memorial Bldg., Napanee, Ont.

Public Health Nurses for York County Health Unit—generalized program. Proximity to Toronto permits possibilities of urban living conditions combined with rural work. Car provided. Health & accident insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

Clinical Instructor (qualified). Salary: $240. **Evening Supervisor** (6:30 p.m.-12:15 a.m.) 44-hr. wk. made up by relieving night supervisor. Salary: $240. **Night Supervisor** (12:15-7:00 a.m.) 44-hr. week made up by relieving evening supervisor. Salary: $235. **Head Nurse** (preferably with pediatric training) for 16-bed children's ward. Salary: $225. **Asst. O. R. Supervisor.** Salary: $220. **Head Nurse** for 27-bed Private Wing by Aug. 31. Salary: $225. **General Staff Nurses** for medical, surgical & obstetrical floors. Salary: $195-205 gross, depending on experience. 44-hr. wk. 2½ days holidays per mo. cumulative to 30 days, $30 charge for room & board. For 177-bed hospital with Training School. Apply Mrs. M. Alexander, Acting Director of Nursing, General Hospital, Medicine Hat, Alta.

Matron for 40-bed hospital in progressive town; pop. 2,500. Situated on excellent highway 135 miles east of Calgary. New nurses' home just completed with suite for matron & own entrance. Town is fully modern with new swimming pool, curling rink, hockey arena, theatre, etc. Salary commensurate with experience & ability. Apply J. A. Bloom, Sec.-Treas., Municipal Hospital, Hanna, Alta.

Clinical Supervisor for Psychiatric Unit, University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Asst. Administrative Supervisor for Operating Rooms for University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 44-hr. wk. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Night Supervisor, General Duty Nurses & Grace Graduates. Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

Clinical Supervisor (qualified) for Jeffery Hale's Hospital, Quebec City, Que. For details apply Director of Nurses.

Night Supervisors for Obstetrical Division & General Duty Nurses for private wards, pediatric depts. in 400-bed General Hospital with Training School. 44-hr. wk. 30 days vacation after 1 yr. All statutory holidays. Residence accommodation available if desired. Good salary. Hospital pleasantly situated, overlooking active industrial city, 65 miles southwest of Toronto. Apply Director of Nursing, General Hospital, Brantford, Ont.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Obstetrical Supervisor & Registered Nurses for General Staff Duty in 140-bed hospital Attractive salary with maintenance. Apply Supt., Soldiers' Memorial Hospital, Orillia, Ont.

Asst. Head Nurses for 60-bed Pediatric-Orthopedic Hospital. Also **Operating Room Supervisor** (fully experienced). Apply, stating qualifications & experience, Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

Obstetrical Supervisor & Surgical Clinical Instructor with special preparation. Gross minimum salary: $240 — annual increments, vacation, sick time. 48-hr. wk. For further details apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Victoria, Australia—Sister-Tutors (Instructors in Nursing Arts, etc.) Several vacancies exist for Sister-Tutors, preferably qualified, in country & city hospitals in Victoria. Assisted passages with contract available. Details from Sec., Hospitals & Charities Commission, 61 Spring St., Melbourne, Australia.

Registered Nurses for General Duty in small General Hospital. Salary: $150 per mo. with full maintenance. 6-day wk., 8-hr. duty—rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holidays after 1 yr. service. Summer bonus for nurses working July, Aug. & Sept. Paid overtime. **O. R. Nurse** by Aug. 31. Salary commensurate with training. Apply Acting Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Duty in County Hospital, Huntingdon, Que. This is a small General Hospital in Town of Huntingdon, 45 miles southwest of Montreal, connected by excellent train & bus service. Pleasant working conditions. 8-hr. duty, 3 rotating shifts. Nurses' home attached to hospital. Attractive community social life. Two theatres, badminton club, skating, curling, dancing & only 8 miles from Lake St. Francis. Salary: $140 per mo. & full maintenance. 3 increases of $5.00 per mo. at 6-mo. intervals. 10 days sick leave per yr. & 4 wks. holiday. Apply to the Matron.

General Duty Nurses urgently needed for vacation period. Monthly salary: $180 plus complete maintenance in nurses' residence. Transportation expenses will be paid. For further information apply Supt., Lady Minto Hospital, Chapleau, Ont.

THE WOODSTOCK GENERAL HOSPITAL SCHOOL OF NURSING

invites applications for

- Public Health Instructor
- Science Instructor
- Nursing Arts Instructor
- Clinical Instructor

POSITIONS OPEN SUMMER.

For information write:

Director of Nursing, General Hospital, Woodstock, Ontario.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Registered Nurses for General Staff for 21-bed hospital. Salary: $160 per mo. with $5.00 increase every 6 mos. to maximum of $180 per mo. Room, board & uniform laundry provided. Rotating shifts, 48-hr. wk. Blue Cross Plan, 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, General Hospital, Espanola, Ont.

Registered Nurses (2). Salary: $165 for 1st yr.; $175 for following yrs. **Practical Nurses (2).** Salary: $75-100 per mo. respectively, depending on experience. Plus full maintenance. 34-bed General Hospital. Reg. 8-hr. shift. 3 wks. vacation for 1st yr., 4 wks. after 2 yrs. 12 days sick leave per year. All statutory holidays. Extra bonus for night duty. Duties to commence Sept. 1. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Registered Nurse for General Duty at Municipal Hospital, Fairview, Alta. Salary: $180 per mo. $5.00 per mo. increase for each yr. of service since graduation to maximum of $195 plus full maintenance. 3 wks. holiday with pay. Separate nurses' home. Apply Sec.-Treas.

Registered Nurses for General Duty in 600-bed hospital for Tuberculosis. Initial gross salary: $185; additional salary for operating room, surgical floor & night duty. Board, room, laundry available — $33 per mo. Fir further information apply Director of Nurses, Beck Memorial Sanatorium, London, Ont.

Registered Nurses for General Duty in busy 70-bed General Hospital. Commencing salary: $180 per mo. for 44-hr. wk. Good personnel policy. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

Registered Nurses for General Duty in 70-bed General Hospital in San Gabriel Valley, 40 min. from Los Angeles. Close to beaches & mountains. 40-hr. wk. 2 wks. paid vacation. 6 mos. increase in salary. Paid hospital insurance. Starting salary: $235 per mo.; $10 differential for afternoons & nights; $10 differential for surgery & maternity. Write for application form Supt. of Nurses, Inter-Community Hospital, Covina, California.

Registered Nurses for supervisory positions & staff nursing in new & beautifully equipped 100-bed hospital in Pacific Northwest. Beginning salary for staff nursing: $270 for 40-hr. wk.; $10 additional for P.M. & night duty. Only 6 miles from Pacific Ocean. Delightful climate. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

Registered & Graduate Nurses for General Duty in 100-bed hospital with complete new Obstetrical Unit. Apply, stating experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

Nurses — vacancies for all grades of nurses & other hospital personnel. Apply International Employment Agency, 531 E. Grand Blvd., Detroit 7, Michigan. (Phone WAlnut 1-8543).

General Duty Nurses (2) for 20-bed hospital in beautiful Arrow Lakes District of British Columbia. Apply, giving experience, references & qualifications, Matron, Arrow Lakes Hospital, Nakusp, B.C.

Supt. of Nurses immediately for Municipal Hospital, Drumheller, Alta. Fully modern new wing, which will house self-contained Maternity Dept., under construction. Bed capacity (now 80) will be 105. Particulars as to salary & personnel policies may be obtained from undersigned. Apply, giving post-graduate training if any, particulars of past employment, and age to Leonard Wilson, Sec.-Treas.

Operating Room Supervisor for 155-bed General Hospital with accredited school, located in mountains of Virginia. Active dept. Immediate plans for 75-bed addition & new surgical suite. Experience & post-graduate work required. Apply Director of Nurses, Chesapeake & Ohio Hospital, Clifton Forge, Virginia.

General Duty, Operating Room & Maternity Nurses. Salary: $182.50 for recent graduates. 1 meal, laundry. 8-hr. day, 4-hr. wk. — straight shift. $15 differential evenings — $10 nights. Vacation sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Graduate Floor Duty Nurses for Mount Hamilton Hospital, (Maternity), Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $100. For other perquisites & further information apply Supt.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Nurse (1) with O.R. experience — salary: $230 per mo. & **General Duty Nurses** for 110-bed hospital. Starting salary: $220 per mo. for B.C. Reg. with annual increase up to $25; less $52.50 for board, room, laundry. 18 days cumulative sick time annually. 28 days vacation after 1 yr. 10 statutory holidays. Excellent golf, swimming, skiing & other recreational facilities. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $240-270. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $280; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

Applications are invited for the position of

DIRECTOR OF NURSING AND PRINCIPAL OF THE SCHOOL OF NURSING

Royal Columbian Hospital, New Westminster, B.C.
(432 beds)

Duties consist of directing Nursing Services and accredited School of Nursing of approximately 175 students. Teaching and administrative experience required. Prefer minimum of 5 years as Director or Assistant Director experience. Excellent remuneration.

Apply, not later than AUGUST 31, giving full details of nationality, training, experience, age, etc., to:

Sec., Board of Directors, Royal Columbian Hospital, New Westminster, British Columbia, Canada.

General Duty Nurses (3). Commencing salary: $225; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

General Duty Nurses for 135-bed modern hospital with facilities for private patients & mild psychiatric cases. Situated on east side of Detroit, close to downtown section. Good transportation. Beginning salary: $260 per mo. with 3 semi-annual increases of $5.00 ea. $15 per mo. for afternoons & $25 per mo. more for nights, above base pay. Apply Miss G. Rashleigh, R.N., Jennings Memorial Hospital, Detroit 14, Michigan.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Supt. of Nurses (1). Night Supervisor (1). Applicants must be Registered Nurses. 52-bed hospital. Apply, stating qualifications, experience & salary expected, Jas. C. Gordon, Chairman, Pontiac Community Hospital, Shawville, Que.

The Province of Manitoba requires **Asst. to Supt. of Nurses** for Infirmary Unit at Hospital for Mental Diseases, Selkirk, Man. Must be Registered Nurse. Applicants should possess some Mental Hospital experience & should be capable of teaching in School of Nursing attached to hospital. Salary range: $2,880-3,240 per annum. This position offers regular annual increases, liberal sick leave with pay, 4 wks. vacation with pay annually & pension privileges. Apply, stating qualifications & experience, Manitoba Civil Service Commission, 247 Legislative Bldg., Winnipeg, Man.

Nursing Instructor at once. Salary: $243.36-293.36 depending on qualifications & experience, preferably with Psychiatric Nursing preparation. 44-hr. work wk. Uniforms supplied. Modern residence. $30 charge per mo. for perquisites. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Municipal Nurses for Province of Alberta. Rural service, emergency treatment, public health & maternity program. Salary: $2,160-3,000 depending on qualifications & experience plus modern furnished cottage. Excellent sick leave, vacation & pension benefits. Apply Director, Nursing Division, Dept. of Public Health, 124 Administration Bldg., Edmonton, Alta.

Graduate Nurses for General Duty. Salary: $193.36-233.36 per mo., depending on qualifications & experience. 44-hr. work wk. Uniforms supplied. Modern residence. $30 charge per mo. for perquisites. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

SUPERINTENDENT OF NURSES

immediately

For well equipped United Church Hospital, operated by the ***Board of Home Missions in Northern British Columbia.*** Well qualified person required. Good working conditions. STARTING SALARY: $275 gross ($40 B. & L. with private suite).

Apply, stating experience with references, to:

Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

Teaching Supervisor for Communicable Disease Division. Salary open. Apply Supt. of Nurses, General Hospital, Regina, Sask.

Operating Room Supervisor for 800-bed hospital. Salary open. Apply Supt. of Nurses, General Hospital, Regina, Sask.

Operating Room Supervisor for Norfolk General Hospital, Simcoe, Ont. Post-graduate training preferred. State date available. Apply Supt. of Nurses, Norfolk General Hospital, Simcoe, Ont.

O.R. Supervisor; Clinical Instructor (medical & surgical); **Science Instructor.** Rate of pay commensurate with qualifications & experience — $230-250. 30 days vacation after 1 yr. service. 7 statutory holidays. 1½ days sick time per mo. cumulative to 60 days. 44-hr. wk., 8-consecutive-hr. day. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Registered Nurses (2) for General Duty in 17-bed hospital about 100 miles from Calgary. Salary: $165 with full maintenance. Increase of $5.00 per mo. after each 6 mos. service up to 3 increases. Transportation refunded after 6 mos. service. Usual vacation & statutory holidays. Apply Municipal Hospital, Elnora, Alta.

Registered or Graduate Nurse (1) immediately for 21-bed fully modern hospital. Salary: $180 per mo. plus $5.00 increase every 6 mos. plus full maintenance & private room in nurses' residence. 8-hr. day, 6-day wk. Regular sick benefits, etc. 30 days holiday with salary per annum. Daily train service to Regina & Saskatoon except Sun. Wire or phone collect Matron or V.L. Gingrich, Sec.-Mgr., Union Hospital, Leroy, Sask.

Registered Nurse for Middlesex County School Health Service by Sept. 1. Car allowance; 4 wks. vacation. Apply W. A. Sutherland, County Clerk, County Bldg., London, Ont.

Registered Nurse (1) & Licensed Practical Nurse (1) for new hospital. Quiet, comfortable living quarters. Attractive salary plus maintenance. Apply Matron, North Norfolk-MacGregor Medical Nursing Unit, MacGregor, Man.

General Duty Nurses for active 60-bed General Hospital. 3 wks. vacation with pay. 7 statutory holidays. Sick leave cumulative. Starting salary gross: $190 per mo. with increments every 6 mos. Apply Supt., General Hospital, Strathroy, Ont.

General Duty Nurse for large Municipal Hospital. Promotional opportunities. 44-hr. wk. Retirement benefits. Salary: $297-354 per mo. Apply Flint Civil Service Commission, City Hall, Flint, Michigan.

Nurses (2) for 16-bed Union Hospital, Maidstone, Sask. Salary: $185 per mo. plus full maintenance. 1 mo. holidays with pay after 1 yr. service. Additional payment of $180 on completion of 12 mos. continuous service. Hospital modern in every respect with new nurses' home to be completed this year, Apply Matron.

Staff Nurses for 300-bed hospital. Opening in all services. 40-hr. wk. with rotating shifts. Salary: $13.88-14.80 per day & time & a half for overtime. Six paid holidays per yr. or double time if worked. 2 wks. vacation with pay & 18 days sick leave without loss of salary annually. 20 min. from downtown Detroit. Apply Director of Nursing, General Hospital, 369 Glendale Ave., Highland Park 3, Michigan.

GENERAL STAFF NURSES

General Wards — O.R. — Obstetrics

190-bed hospital

Pleasant city of 33,000 — Two colleges

Good salary and personnel policies.

For further information apply to:

Director of Nurses, General Hospital, Guelph, Ontario.

Asst. Night Supervisor & Registered Staff Nurses for Communicable Disease Hospital. Apply Acting Supt. of Nurses, Alexandra Hospital, 230 Charron St., Montreal 22, Que.

O.R. Supervisor, Head Nurse & General Duty Nurses immediately for 80-bed hospital — new wing, modern Operating Room. Apply, stating salary expected, experience or special qualifications, Director of Nursing, Lachine General Hospital, Lachine, Montreal 32, Que.

Registered Nurses for new 52-bed hospital, approx. 50 miles from Ottawa — English-speaking community. Full maintenance, sick leave & annual holidays. 8-hr. general duty. Apply Supt., Pontiac Community Hospital, Shawville, Que.

Clinical Teacher for 34-bed Surgical Dept. Salary according to experience & qualifications. Apply Director of Nursing, General Hospital, Sudbury, Ont.

General Duty Nurses for Operating Room. Salary at rate of $2,340 per yr. Apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Supervisor (experienced) to act as **Asst. Supt.** Day duty only — 44-hr. wk. This is a general supervisory position in active 50-bed hospital close to Toronto. Apply, giving full particulars as to age, qualifications, experience & references, Supt., General Hospital, Cobourg, Ont.

General Duty Nurses & Certified Nursing Assts. for 107-bed modern hospital. Starting salary for nurses: $175 per mo. plus meals & laundry. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ont. refunded after 6 mos. service. 44-hr. wk. 8 statutory holidays. 21 days holidays with pay. Cumulative sick time. Medical & hospital plan subsidized. Room accommodation available in residence. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Public Health Nurse as soon as possible. Starting salary: $2,496. Previous experience qualifies for higher salary. Cost of transportation to Port Arthur refunded after working for 3 mos. Car allowance or free transportation while on duty. Pension plan after 3 yrs. service. Applications, stating qualifications & experience, will be received by A. H. Evans, Sec., Board of Health, Port Arthur, Ont., on or before Aug. 20.

Public Health Nurses (3) immediately. Present minimum salary: $2,400. Generalized program. Car provided. Health & Accident Insurance. Apply Sec.-Treas., Alberta East Central Health Unit No. 10, Stettler, Alta.

Public Health Nurse for Greater Montreal Branch of Victorian Order of Nurses. Interesting program of nursing care & health counselling in homes. Stimulating staff education program. 5-day wk. 4 wks. vacation. Initial salary: $2,700. Annual increments. Apply District Director, V.O.N., 1246 Bishop St., Montreal 25, Que.

Registered General Duty Nurses immediately for active 31-bed hospital. Comfortable living accommodation. Gross salary: $200 less $35 for full maintenance. 3 wks. vacation after 1 yr. Apply Supt., Little Long Lac Hospital, Geraldton, Ont.